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JOURNAL
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A closer look at medical incompetence and the Medical Practice Act



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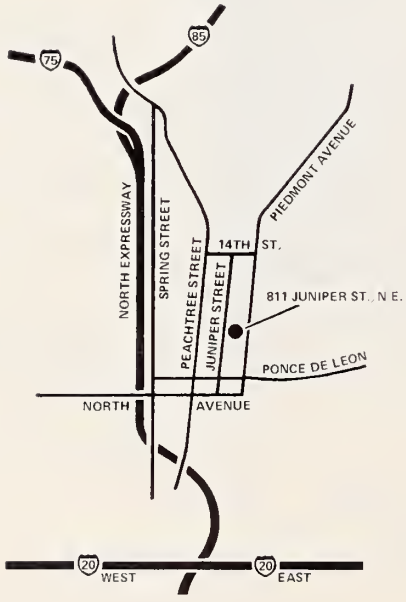
THE COVER

This month the *Journal* examines the newly strengthened Medical Practice Act. In two articles MAG members review procedures for dealing with the unethical or incompetent physicians. Designed by Bob Hamill.

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JOURNAL
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Insuring Competence and Improving Discipline Through the Medical Practice Act

WILLIAM J. MORTON, M.D., *Cairo**

CONSUMERISM IS A TERM we have all become familiar with over the past few years. Public and even professional outcries still ring in our ears, and we are bombarded with complaints and charges to "clean house."

Just how bad is professional incompetence and are we really doing anything to improve medical discipline?

A recent article in *American Medical News* quotes Robert Derbyshire, M.D. of Santa Fe, N. M., a former president of the Federation of State Medical Boards and an authority on medical discipline. He says, "Hospitals, medical societies, and state licensure boards are not doing the job of protecting the patient they should. Hospitals are guilty of being lax in regard to the physical and psychological standards of staff members. A common reason for shielding the unethical physician is the fear of lawsuits, a fear which often borders on paranoia. If hospitals and authorities take the proper action adhering to their bylaws, their chances of being sued are remote." He further contends, "State medical examining boards are hampered by political and court interference, a lack of cooperation from hospital and medical societies, and the vagueness of the term 'professional incompetence.' "[1]

Short on Staff, Funds

This same article also points out that most state boards are understaffed and short of funds. Georgia is certainly no exception. Each year we are at the mercy of the legislature, who looks to us to implement and enforce the law, yet budgets us far less than we turn into the general fund. Also, we must share a small investigative division with some 37 other licensing boards.

We are all aware that the practice of medicine is a privilege granted by legislative authority. In the interest of public health, safety and welfare, it is necessary to provide laws for the granting of that privilege and its subsequent use, to the extent that the public shall be properly protected against unprofessional, improper, unauthorized, and unqualified practice of medicine. Thus the Medical Practice Act can only be accomplished by legislative action. The Board of Medical Examiners is then charged by the legislature with the implementation and enforcement of the law, and it has the authority to make judgments and impose penalties and conditions within the framework of that law.

So what are we doing in Georgia to insure competence and improve discipline?

Cooperation of Organized Medicine

For several years prior to the 1973 legislative session, the Board of Examiners along with the Medical Association began to formulate ideas for changing and improving the disciplinary section of the Medical Practice Act. Considerable thought was given to expanding disciplinary procedures, and a section was included to cover the "sick physician." It was apparent that for these changes to be effective, there would have to be close cooperation between the Board of Medical Examiners and organized medicine. Local, district and state societies indicated a willingness to participate in disciplinary procedures if they could be afforded some immunity from lawsuits. This was accomplished in the new changes by giving the Board the power to recommend to the

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Secretary of State the employment or appointment of such personnel that are necessary to assist the Board in the performance of its duties. Thus these people would become agents of the Board, and, in fact, agents of the State.

These disciplinary changes along with other improvements in the Medical Practice Act, were introduced as House Bill 612 which passed the legislature with an overwhelming majority and was signed into law in March 1973. These significant changes are reflected in Chapter 84-902 and 84-916 of the Medical Practice Act.

Increase in Complaints

With the implementation of these changes, the Board has had a four-fold increase in the number of complaints. Since January 1975 we have received over 100 complaints. Many of these have been referred to the local and disciplinary committees who have and are doing an excellent job. These committees are recommended by the Board and appointed by the Secretary of State. They are charged with investigating and determining the validity of a complaint but do not engage in the adjudication or final disposition of a case. They have functioned well as an additional investigative arm of the Board.

Several "sick physicians" have been called before the Board. Some have had their licenses revoked and others have returned to practice through effective counseling and treatment, and most remain on probation. Recently the Board met with G. Douglas Talbott, M.D. to formulate additional plans to implement the "sick physician" section of the law. (Dr. Talbott is medical director of the DeKalb Alcohol and Drug Programs and chairman of the Disabled Doctors Committee for Georgia.)

But have the recent changes really helped to improve medical discipline? At this point it's too early to speculate. We do, however, have a much more effective means of dealing with disciplinary problems. Prior to these changes the Board only had the authority to grant a license or revoke it. Now we have several options. This is outlined in detail in Chapter 84-916 but can be briefly stated as follows: (b) (1) When the Board finds that any person is unqualified to be granted a license or finds that any person should be disciplined pursuant to subsection (a) of this Code Section, the Board may take any one or more of the following actions:

(i) Refuse to grant a license to an applicant; or

(ii) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licentiate; or

(iii) Suspend any license for a definite period; or

(iv) Limit or restrict any license; or

(v) Revoke any license; or

(vi) Condition the penalty, or withhold formal disposition, upon the physician's submission to the care, counseling, or treatment of physicians or other professional persons, and the completion of such care, counseling, or treatment, as directed by the Board.

(2) In addition to and in conjunction with the foregoing actions, the Board may make a finding adverse to the licentiate or applicant, but withhold imposition of judgment and penalty, or it may impose the judgment and penalty but suspend enforcement thereof and place the physician on probation, which probation may be vacated upon noncompliance with such reasonable terms as the Board may impose.

(c) In its discretion, the Board may restore and reissue a license to practice medicine issued under this Chapter or any antecedent law, and, as a condition thereof, it may impose any disciplinary or corrective measure provided in this Chapter.[2]

I feel that we have taken some significant steps to insure professional competence and improve medical discipline. However, it is imperative that we continue to impress the public and the legislature that without adequate personnel and funds, these measures cannot be effective. Combined efforts between organized medicine and the Board have informed the public that we are aware of the problem and are moving to correct it. This combined effort to enact legislation and effectively implement it has also put the profession "on notice." At the same time we have obligated ourselves to the public and the profession to continue to work to improve the high standards of medical care. ■

REFERENCES

1. *American Medical News*, Oct. 6, 1975, pp. 11-13.
2. Medical Practice Act of Georgia, 1974 Edition.

What It Is Like to Be Involved as a Peer in the Medical Practice Act

LEON E. CURRY, M.D., *Metter

For too long Georgia along with many other states adhered to the principle that a profession could and should police its own ranks with little or no judicial process. With the introduction of more and more third party payment plans and government programs, the profession seemed to "slip" a little in policing itself, and the physicians of Georgia became somewhat reluctant to charge fellow physicians of poor practice techniques, etc., fearing recriminations and practice jealousy counterchanges. The machinery for "professionally pressuring" one's peers to meet expected standards of practice became rusty, due to disuse, and physicians were inclined to play ostrich with regard to suspected poor medical practice of colleagues.

Recognizing the need for professional standards enforcement and recognizing that the machinery for investigation was not a statutory provision, the Medieal Practice Act of Composite State Board of Medieal Examiners of 1974 was passed, with enthusiastic support of the MAG.

This act provided the Composite State Board of Medical Examiners with necessary authority, staffing, and funds to conduct its own investigations. It also allowed the Board to appoint physicians as temporary peer committees to assist in conducting these investigations. Where violations of the Medical Practice Act were discovered, the Board was empowered to prosecute, penalize, suspend, and/or revoke licenses of offenders.

As a member of a team asked to function as a true peer committee under this statute, I have been asked to explain briefly how it works, and to share the feelings of our committee as we undertook to meet these responsibilities.

Duties Outlined

I was called by a member of the Composite Board and asked if I would serve on a three physieian committee to investigate a certain case. I gladly accepted. A date was set for the investigation and we met in the county courthouse in the city under investigation. Mr. Cecil Clifton, Secretary of the Composite Board, a physician member of the Board, and an agent of the State Examining Boards, Investigating Division of the State Department, carrying a badge, a gun, and the necessary legal documents met with us and outlined our duties under Georgia Code 84-902 Section C. This section provides immunity to those physieians so appointed as an arm of the government, so they are protected from suit by those whom they are investigating.

After we were properly sworn in we were provided certain background objective information obtained from preliminary investigations by agents of the State Department. A great deal of caution was exercised so that prejudicial feelings would not be generated by those who had some knowledge of the allegations in this case. Our job was to investigate, not to pass judgment. Armed with proper authority to scarch, subpoena reeords, and administer oaths for sworn statements, we made our way to the local hospital, announced our purpose, and requested certain records from the hospital, which after some slight delay, were finally given us for examination.

Minutes of the staff meetings were carefully reviewed as they pertained to the case at hand. Patient eharts were examined in detail. Operating room log books were examined. Laboratory reports, operative notes, progress notes, consultative notes, and certain hospital administrative correspondence were reviewed.

The acting chief of the medical staff was ealled in and testified to this three-physician peer committee under oath. He was questioned intensively and invited to volunteer any and all information he had relative to this case. His training and background, and the training and backgrounds of all the current staff members were reviewed, as well as the qualifieations, experience, and training of the physieian being investigated.

The circumstances under which this physician was being charged with violation of the medieal practice act were carefully evaluated, as well as the alleged violations themselves. The total effect on the whole eommunity of the alleged violations was considered and investigated. We were not restricted from investigating any avenue that might have some bearing on this case.

Physician Faced With Charges

Next, the physician under investigation was interviewed in his office and the charges were discussed.

* P.O. Box 267, Metter, Ga. 30439. Dr. Curry is a vice councilor from the First District, a member of the Communications Committee, and an ex-officio member of the Ad Hoc Committee on Physician's Assistants.

The alleged facts, as well as the surrounding and background circumstances were examined in great detail. The physician was most receptive to this committee of peers and appeared to cooperate in every way.

The former chief of staff of the hospital was interviewed at his home. Likewise, he was candid, and frank in his revelation of the actions of the charged physician, the staff, the hospital administration and the repercussions that had taken place within the hospital staff.

After a full 12 hour day of investigation the three of us sat down together and reviewed the information we had obtained. We had found some definite data relative to the alleged charges. Some definite findings regarding unusual methods utilized in suspending a member from the hospital staff were also noted.

Our task was to distill from all this data, opinions, statements and other factual material, and the far reaching circumstances under which certain actions had taken place, a concise report to the Composite State Board of Medical Examiners. We were not to exercise judgment, recommend penalty, or in any way to usurp the Board's responsibility for determining what further action, if any, might be taken. We were however, encouraged to fully report evidence of other illegal, unusual, or wrongful activities encountered, and explain circumstances, so that the Board might understand fully the formal charges and allegations which it had to resolve, and wisely enforce the Medical Practice Act.

The peer committee functions as a purely fact-finding committee for the Composite Board. The Board then sits in judgment and decides what actions if any, are to be taken.

Peers Employed

This system of administering the Medical Practice Act deserves some applause because it does employ true peers of the physician under investigation. It is kept initially in the hands of professionals (in the medical, not legal, profession) where medical knowledge and experience is so essential in formulating an opinion of "wrongdoing," versus "acceptable alternative medical management techniques," which do not constitute wrongdoing.

Only after investigation by true peers is the case considered by the professional medical people on the Composite Board, who may then implement legal professionals, if needed, to finally adjudicate the case. By keeping it in medical hands longer, the allegations are less threatening initially, and much more apt to be understood properly by the medical professionals utilized in investigating the case.

I was glad to give freely of my time to continue to preserve the tradition of self-policing my profession. It seems to me to be an inherent responsibility we all just accept in order to keep our profession free of further bureaucratic intrusion.

There is no greater fulfillment than working to bring about justice to a wronged individual, be he patient or doctor, knowing that the effort will in fact preserve and protect our right and responsibility to police and protect our honored profession. ■

GYNECOLOGIC ENDOCRINOLOGY

A Postgraduate Education Course for the Practicing Physician

The Department of Obstetrics and Gynecology at The University of Tennessee Center for the Health Sciences, Memphis, Tennessee will sponsor a three-day postgraduate course for clinicians on **Gynecologic Endocrinology** at the Hilton Inn-Memphis Airport, March 11-13, 1976. The diagnosis and management of the major gynecologic endocrine disorders will be discussed by 11 visiting faculty and 10 local faculty. Guest faculty include: Drs. Carl E. Cassidy, Charles Flowers, Joseph W. Goldzieher, Robert B. Greenblatt, Jerome M. Hershman, Ronald K. Kalkhoff, Janet W. McArthur, Robert L. Rosenfield, Pentti K. Siiteri, Leon Speroff and Michael E. Yannone. An interesting and informative program is also planned for the wives, including a pilgrimage to restored antebellum homes. For further information and registration contact: James R. Givens, M.D., 800 Madison Avenue, Memphis, TN 38163.

Return of sensibility to an injured hand is of extreme importance if purposeful function is to be restored.

Repair of Nerves in the Hand—When? Where? How?

JAMES L. BECTON, M.D., *Augusta**

THE HAND WHICH HAS lost sensibility by a laceration of one or more of the nerves innervating it has lost its most important function. The loss of motor function is seriously disabling also, but even when motor function is restored by reconstructive tendon transfers the hand is of little use to the patient unless partial sensibility is restored to the skin of the digits. The importance of this sensibility can be demonstrated to you the surgeon by having you touch your eyes, nose and lips with your index and long fingers and then repeating this with your fingers crossed. Proper orientation of sensation is obviously important for purposeful function of the hand.

Diagnosis

The patient who presents with a laceration, stab wound or bullet wound of the forearm or hand should be examined specifically for loss of sensation as well as for loss of tendon function and muscle function. This can be done with paper clip, pin, or pinched with forceps on each side of the fingers and thumb and in the dorsal aspect of the thumb web space. The surgeon who has the knowledge of the specific distribution of the three major nerves of the hand is better off at localizing the specific nerve injured. However, the surgeon who treats hand injuries only occasionally can make the diagnosis by recording the specific area of decreased sensation and can see that proper follow-up and referral for nerve repair is done.

Recognizing the classic habitus of the resting hand in which there has been a specific nerve injury is also helpful in establishing the diagnosis. By following a routine for muscle testing of the muscles of the forearm and hand will establish the diagnosis.

High Radial: Laceration over lateral aspect of elbow or in posterior aspect of upper arm through the triceps muscle. There is a wrist drop and inability to extend fingers at M.P. joints. There is sensory loss over the dorsal aspect of the thumb web.

Low Radial: Laceration over radial aspect of forearm. There is loss of sensation over thumb web. No motor function loss unless tendon laceration is associated. The radial nerve does not innervate any muscles in the hand.

High Median: Laceration in antecubital fossa may be associated with injury to brachial artery. There is loss of sensation on both the radial and ulnar sides of the thumb, index and long and radial side of ring fingers. The thenar muscle function is lost and the thumb cannot be positioned in the position of opposition. The flexor muscles of the distal and middle joints of the fingers (Profundus and sublimis) and the distal joint of thumb (flexor pollicis longus) are lost. Forearm pronation (pronator teres) is absent.

Low Median: Laceration is at the middle of the volar aspect of the distal ⅓ of the forearm, wrist or carpal canal. There is loss of sensation on the radial and ulnar sides of the thumb, index, long and radial side of ring fingers. The thenar muscle function is lost and the thumb cannot be positioned in the position of opposition.

High Ulnar: Laceration at the posterior medial aspect of elbow. There is loss of sensation on both the radial and ulnar sides of the little finger and the ulnar side of the ring finger. The ability to spread the finger and close them is lost. The intrinsic muscles are not functional. It is helpful to palpate the first dorsal interosseous when making the examination. The flexor carpi ulnaris is nonfunctional and flexion of the distal joint of the little finger is weak or absent.

Low Ulnar: Laceration on the ulnar aspect of the distal ⅓ of the forearm and wrist or hypothenar area of hand. There is loss of sensation in the little finger. The ability to spread the fingers is lost. (Interosseous muscles) loss of adduction of thumb. Froment's Sign: Flexion of distal joint of thumb when the thumb is pinching the index finger.

Digital Nerve: Laceration in the palm or the fin-

* Augusta Orthopaedic Clinic, P.A., 1521 Anthony Road, Augusta, Ga. 30904.

ger. Loss of sensation on the side of one finger or if in palm may involve adjacent sides of fingers. No motor function loss.

In an old laceration of these nerves the skin of the invloved area of the hand will be smooth and will have lost the ability to sweat. There may be more than one nerve cut as is seen at the wrist with the median and ulnar and the subsequent development of the claw hand deformity.

Once the diagnosis is established then plans for early repair should be made. The problem then arises of who should do the nerve repair—general surgeon, orthopedic surgeon, neurosurgeon, plastic surgeon or hand surgeon. It should be a surgeon who has the knowledge, interest, patience and technical ability to repair the nerve and the will to follow the patient for the next two to five years while regeneration takes place. During this period contractures are to be prevented, by proper splinting, neurotropic ulcers are to be managed and prevented if possible. Tendon transfers may be necessary if there is only partial recovery. A re-education program for sensation in the hand needs to be carried out. If this is not "your thing" then the patient may be better off if he is referred to someone who has a special interest in it.

When?

The controversy as to whether it is better to do an immediate or delayed repair of lacerated nerves has strong supports for each group. There is a real need for delayed repair when dealing with military nerve injuries, with civilian and industrial injuries which are dirty and severely traumatized and with civilian gunshot wounds. There is another group that feels that delayed primary repair of peripheral nerves on the fifth day following debridement and closure of the wound and when there is no evidence of wound infection. The type of wound whether it is tidy or untidy helps us make our plans for repair. The delayed repair is best done within three to six weeks of the injury.

The basic physiology of the injured nerve cell should be considered. The peripheral nerve is a group of axons covered by their sheath extending from the anterior horn cell in the spinal cord. These cells initially undergo swelling following injury to the flow of axoplasm in the peripheral nerve. The distal segment of the peripheral nerve undergoes Wallerian degeneration and atrophy of the nerve. Therefore, it appears that the ideal time for nerve repair is from one to six weeks depending on the type of injury.

A nerve may be contused or compressed (neuropraxia) and there is impairment of conductivity with incomplete paralysis and loss of sensation. Recovery takes place in a few days or weeks and no repair of the nerve is necessary. When the axons are actually injured but continuity is still present (axonotmesis) recovery occurs as they grow down the Schwann tubes; this will take several months. If the nerve is completely cut (neurotmesis) recovery is impossible without surgical repair.

Where? (At What Level) and Why?

At what level should the lacerated nerve be repaired? The digital nerve should be repaired in the palm and digit to the level of the distal joint crease. At that level it branches into several small branches and repair is impossible.

The high radial nerve laceration at the elbow or above is repaired for motor recovery to the extensor muscles of the wrist and fingers and thumb. The odds of having some recovery following a proper repair are good. Sensory recovery is of secondary importance since only the dorsal aspect of the thumb web is supplied by this nerve.

The low radial nerve laceration is best treated by resecting the nerve at a level beneath the brachioradial muscle so the neuroma is imbedded beneath the muscle and not vulnerable to repeated small trauma. Repair of this nerve is not satisfactory. The loss of sensation is of no functional loss.

The high median nerve laceration near the elbow or above is repaired primarily for recovery of sensation in the hand. Since this is a mixed nerve high in the arm results of repair are not as good relatively.

The low median nerve laceration at the wrist is repaired in an effort to recover partial sensation in the index and long fingers and the thumb, the "eye of the hand region." Opposition can be reconstructed by an opponensplasty if thenar function does not recover.

The high ulnar laceration at the elbow is repaired for return of protective sensation in the little finger and intrinsic muscle function. However, seldom does one recover intrinsic muscle function. Intrinsic transfer or capsuloplasty (Zancolli procedure) can be done to prevent clawing of the little and ring fingers.

The low ulnar nerve laceration is repaired for sensation and intrinsic muscle return. Intrinsic transfer for clawing of ring and little fingers may be necessary.

How?

How should the repair of the lacterated nerve be done? First there should be a surgeon and assistant surgeon who are accustomed to working together. This team should be familiar with using the dissecting surgical microscope. The microscope gives excellent magnification. It also provides excellent lighting and is a real adjunct in doing a detailed accurate re-

pair of the funiculus. After the patient is given general anesthesia and the upper extremity has been prepped with Betadine soap and solution to the upper arm level a pneumatic tourniquet is applied. The pneumatic tourniquet is inflated to the level above arterial flow, usually at approximately 250 millimeters of mercury. This allows for a bloodless field in which to operate.

Exposure: There should be adequate exposure. The skin incision should be outlined on the arm or hand so that the proximal course of the nerve can be mobilized if need be and that at the end of the procedure a full thickness skin flap will be available to give a satisfactory closure over the repaired nerve.

Mobilization: The nerve must be sufficiently mobilized to avoid tension at the suture site. This may require transferring the ulnar nerve anterior to the elbow or releasing the median nerve from between the two heads of the pronator teres. If the laceration is near the wrist then the carpal tunnel should be opened and released. If after mobilizing the nerve area there is still a gap between the ends of the nerve then a nerve graft should be done. The sural nerve is taken from the leg as a donor nerve and segments of this nerve are then sutured in place to cover the gap. It is important that there be no tension at the site of the nerve repair.

The funicular repair is done with 8-0 virgin silk. The ends of the nerve are trimmed off so that corresponding funiculi can be identified and can be approximated with the 8-0 silk. Once the major funiculi have been approximated then a perinural repair suture is done with 6-0 silk. The tourniquet is released, hemostasis is maintained, the skin is closed loosely, then a bulky dressing is applied with the initial dressing consisting of fluff gauze which is wet with Bunnell solution. Additional padding is applied. The wrist and elbow are flexed as necessary, however, acute flexion of any joint should be avoided. Plaster of paris splints are then applied for secure immobilization of the wrist and elbow. This immobilization is carried out for six weeks and then the wrist and the elbow are gradually extended at each time the cast is changed, which is every week.

The patient should be followed at intervals for a period of at least two years for return of sensation. The re-generating nerve fibers take one month to cross the repair site and then advance down the nerve trunks at approximately a millimeter per day or one inch per month. The Tinel sign is elicited at each examination by starting distally and tapping over the peripheral nerve proximally and noting the area of maximum tingling.

The hand and wrist should be splinted so that contractures are prevented during the postoperative period while you are waiting for the nerve to re-generate. Re-generation is faster in a young child

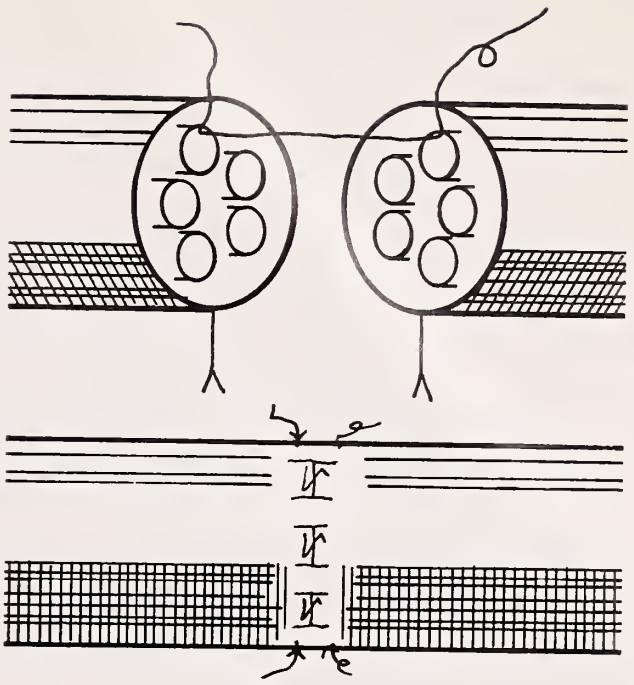


FIGURE 1

Illustration of Funicular Repair. The intermediate nerve components are sutured by placing stitches in their connective tissue membranes.

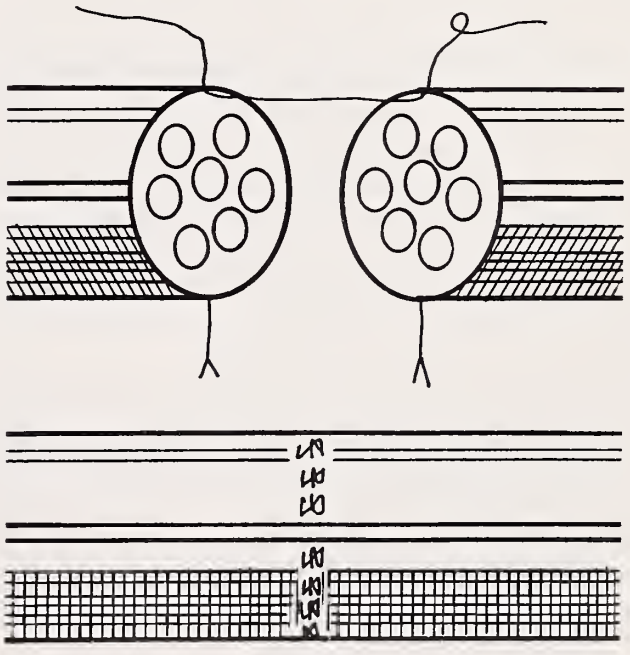


FIGURE 2

Illustration of Epineural Repair. Stitches are placed in the outer loosely applied layer. Poor alignment of internal structures occurs because of gap between funiculi, overriding, buckling and straddling.

and the young adult and it is slowest in the older adult.

A re-education program of sensation in the hand following nerve injury is important. The patient is given various objects to handle and he identifies these first with his eyes open and then later with his eyes closed. This allows visual co-ordination for interpretation for both constant touch and moving touch.

Prognosis

The best results following a nerve repair are obtained when the following factors have been considered when doing the repair.

1. Accuracy of the funicular alignment which is aided by using the microscope for magnification.
2. Repair with the finest atraumatic suture technique.
3. Minimal tension at the nerve repair site.
4. Minimal scarring at the nerve repair site.

The factors which effect the end results are:

1. The age of the patient. The younger the patient the better is the result of the nerve repair.
2. The type of repair. When the funicular repair is done with magnification there is a better repair than when a few large silk sutures have been used to grossly anastomose the nerve.
3. The type of injury. A sharp laceration of a nerve will give a better repair than if there has been crush or blast injury involving the nerve such as is seen in industrial injuries or in war injuries.

The level of the injury:

The more proximal the laceration the poorer the result of a nerve repair. The further the axons have to grow down the remaining Schwann cell tubes the poorer the results. The best example of this is the good result seen following a repair of the motor branches of the radial nerve at the above elbow level where there is only a few millimeters for the nerve to grow and the poor result following median and ulnar nerve lacerations at the elbow.

Length of time from injury to repair:

It appears that the best time for repair is immediate or within the first six weeks following injury. However, the nerve should be repaired even if there has been several months delay from the time of the laceration. Some protective sensation to the digits is better than no sensation at all.

Tension at the suture line:

The repair should be done so that there is no tension at the suture line. The nerve should be mobilized proximally so that there is no tension on the nerve repair site. If there is tension, then a free nerve graft should be done.

The length of the nerve gap:

If there has been considerable loss of nerve then a nerve graft will be necessary and this is an unfavorable factor for repair of the nerve.

Vascular supply to the nerve:

The nerve should lie in a healthy bed of soft tissue and not lie in a mass of contracted scar as is seen in a Volkman's Ischemic Contracture.

Presence of open distal axon tubes:

The exact time the distal axon tubes remain open is not known. However, it is believed that after 12 to 18 months there are irreversible changes in the muscle for adequate re-generation.

Bed for repair:

There should be adequate soft tissue and full thickness skin flaps to cover the nerve following the repair.

Infection:

The problem of infection is ever present and a beautiful repair of a nerve can be completely destroyed by a postoperative infection.

Disability ratings after nerve laceration:

You would hope that a nerve would have complete recovery following repair, however, seldom does this occur in the adult. Therefore, the treating physician must assign a physical impairment rating. The AMA Guide to the Evaluation of Permanent Impairment serves as a standard reference for assigning a disability. Each individual case is evaluated on its own merit. Impairment of the upper extremity is based on the loss of function due to sensory deficit, pain or discomfort and the loss of function due to loss of strength. For a high median above elbow, impairment from 0 per cent to 73 per cent. For a low median, the low mid forearm, impairment from 0 to 61 per cent. The high radial injury may have an impairment from 0 to 43 per cent. The high ulnar injury may have an impairment from 0 to 42 per cent of the upper extremity. The low ulnar injury may have an impairment from 0 to 33 per cent.

The degree of sensory return in the area can best be measured by the two point descrimination as measured for various areas of the hand. This is done by using a paper clip and testing to see at which point a two point pressure will feel only as one point.

The actual way that the patient uses the hand and particularly the presence of any calluses in the hand will help to tell whether the effected area is a functional value to the patient.

The prolonged follow up of the patient who has sustained an injury to a peripheral nerve is most important and should be considered and re-inforced to the patient that there is such a need even at the time plans are being made for the repair of the digital nerve. ■

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Case report and review of current treatment methods.

Tuberculous Spondylitis

LESLIE L. WILKES, M.D. *and* RUDOLF A. COLMERS, M.D., *Savannah**

In past generations physicians and surgeons have dealt daily with skeletal tuberculosis. In this generation, thanks to advances in pharmaceuticals and public health measures, extrapulmonary tuberculosis rarely is seen. In the past 10 years in Savannah there have been four other cases of spinal tuberculosis. The authors wish to demonstrate that spinal tuberculosis still occurs and may give rise to common, nonspecific symptoms such as low back pain. Furthermore, even though the incidence is reduced, the complications may be grave. Therefore, those involved in treating bone and joint disease must maintain a high index of suspicion in order to diagnose this disease; and we must periodically review the current methods of treatment.

Case Report

T. L. P., a 31 year old black male laborer, was admitted in November 1974, for upper lumbar back pain and right flank pain. The symptoms had begun insidiously four months previously and had gradually worsened. Further inquiry revealed a history of generalized malaise, evening fevers, night sweats, anorexia, and a 30-pound weight loss. Examination revealed a chronically ill febrile male with tenderness to deep pressure over the thoracolumbar area of the spine. Slight swelling was noted lateral to the spine. There was no neurological deficit. Significant laboratory work on admission revealed a hemoglobin of 8.1 gm%, WBC 7.6 $\times$ 10^3, lymphocyte/monocyte ratio 1:33; and a corrected ESR 60 mm/hr (Wintrobe). Serum electrophoresis revealed a mild increase in the alpha 1, alpha 2, and gamma globulins. Normal laboratory work included SMA, VDRL and urinalysis. Admission roentgenograms of the chest, dorsal spine, and lumbar spine were originally interpreted as normal. In the course of performing an upper GI series, abnormalities of the paraspinal soft tissues were noted. Follow-up laminagrams revealed a one centimeter diameter lytic lesion in the 10th dorsal vertebra and a large paraspinal abscess (Figures 1-3). Intermediate strength PPD was markedly positive.

During the first week of hospitalization there were consistent evening temperature elevations in the range of 101 to 102 degrees F. orally. On the eighth hospital day the paraspinal abscess was evacuated by costotransversectomy. Large amounts of necrotic and caseous material were removed. Postoperatively, closed suction chest drainage was required. Isoniazid (INH) was started preoperatively and Ethambutol was added immediately postoperatively. Streptomycin was begun as soon as histological conformation was obtained showing caseating granulomatous inflammation consistent with tuberculosis. Unfortunately, the material was not concentrated prior to culture; and therefore, we were not able to demonstrate tubercle bacilli by culture. The clinical course was quite dramatic, showing immediate improvement in the fever and malaise, and gradual recovery of the appetite and weight. The wound healed per primam, and ambulation was encouraged immediately following removal of the chest tubes. Streptomycin was continued for two months. The other drugs will be given for 18-24 months. The present regimen consists of INH 300 mg/day, Pyridoxin 50 mg/day, and Ethambutol 800 mg/day. When last seen five months postoperatively he remained asymptomatic.

Discussion

Tuberculous spondylitis was first described accurately by Percivall Pott in 1779, although the disease was known to Hippocrates and was mentioned in his writings in the third century B.C. In the preantibiotic era, the treatment was only supportive with occasional needle aspiration. The advent of Streptomycin permitted open surgical drainage with a reduction in mortality and morbidity. During recent years, the trend has been toward more radical surgery. However, recent reports in the British literature raise questions as to the necessity of such radical

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FIGURE 1

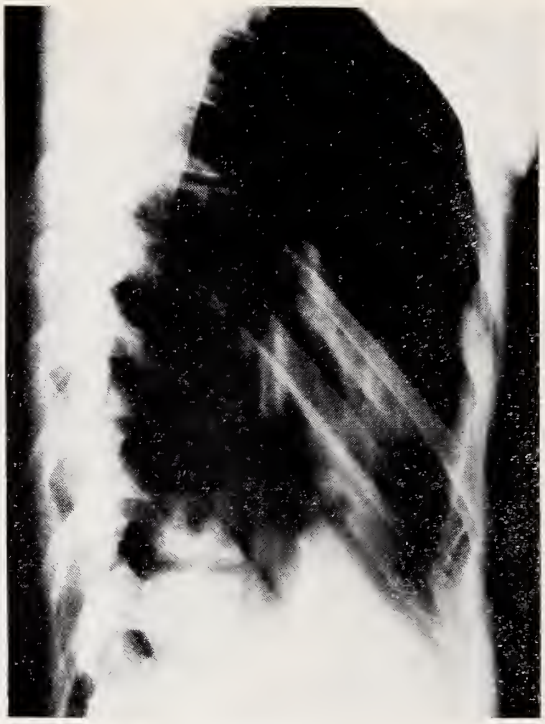


FIGURE 2

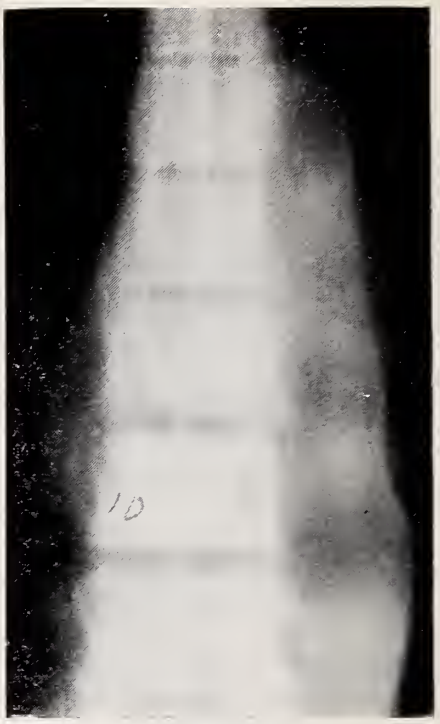


FIGURE 3

treatment by showing surprising results with chemotherapy alone.

In 1958, Roaf summarized the accepted surgical opinions of the day in his editorial in the *Journal of Bone and Joint Surgery*. He recommended that "most" patients should be treated by debridement, drug therapy, recumbancy, and arthrodesis of the spine at a later date. In 1960, Hodgson of Hong Kong took one step further by recommending debridement, total excision of the tuberculous foci, and anterior spinal fusion as a one stage procedure as soon as possible on all patients. Certainly, the Hong Kong experience has shown rapid and consistent healing; but it must be kept in mind that the anterior procedure is formidable, technically difficult, and applicable only to certain centers.

At the same time Hodgson was developing his radical operation, Konstann in Nigeria reported his results on ambulant outpatients with INH and PAS alone using neither recumbancy, casts, nor surgery of any type. The results were said to be equally as good as those obtained by other methods. Because of these conflicting reports the (British) Medical Research Council set up a prospective study conducted in Korea, Rhodesia and Hong Kong. Results in 700 cases have now been published and were recently summarized in an editorial in the *British Medical Journal* (Table 1). From these data there seems to be very little difference in the percentages of healed lesions whether the patients are treated by chemotherapy alone or in combination with recumbancy, debridement or spinal fusion. The addition of Streptomycin to random cases for three months, likewise, had no effect. There was, however, an increase in the kyphosis an average of 15 degrees in the ambulant non-operated group. Debridement or debridement and fusion produced more rapid healing with no progression in the kyphosis or late paraplegia. Therefore, this method combined with chemotherapy should still be considered the treatment of choice in patients with extensive disease who can withstand the procedure and in areas where proper facilities exist. Hodgson has said that surgery is indicated in all cases, if only for conformation of the diagnosis.

In cases as we have presented where the abscess is large but the bony lesion is small, debridement only is required. In lesions involving large portions of the vertebral body debridement should be coupled

TABLE 1

MEDICAL RESEARCH COUNCIL PROSPECTIVE STUDY 700 CASES SPINAL TB RESULTS 18 MONTHS AFTER COMPLETION TREATMENT

	Masan Korea	Pusan Korea	Bulawayo Rhodesia	Hong Kong
Ambulant outpatients chemotherapy* only	100	75	63	
Chemotherapy and 6 mo. in hospital	100	75		
Open debridement plus chemotherapy			67	66
Debridement/fusion plus chemotherapy				64
Satisfactory results (Radiologically healed) (No CNS disease) (Abscess disappeared) (Sinuses healed)	88%	82%	86%	86.5

* Chemotherapy = INH and PAS for 18 mo.

Data compiled from: Tuberculosis of the spine; *Brit. Med. J.*, No. 5945, Vol. 4, 613-614, 1974.

with spinal fusion. In developing countries where surgical facilities are less than optimal, drug therapy alone seems to have its place.

Changes in Drug Therapy

Drug therapy of tuberculosis has undergone revolutionary changes within the last decade. Present treatment is based upon intensive and prolonged use of specific bacterial antagonists. Since healing depends on body defenses and is aided by specific drug therapy, it has to be continued for a prolonged course of time, namely, 18 to 24 months. Single drug therapy is to be condemned since it frequently will lead to early emergence of resistance. It is important that multiple drug therapy be started from the beginning, and drugs should be given in such a manner that single daily peak concentrations are reached. The major chemotherapeutic agents which are presently in use interfere with vital functions of the microorganisms. These agents, their actions, and their side effects are briefly outlined in the accompanying table (Table 2).

It is generally agreed that INH remains the primary drug in tuberculosis. Recently, Ethambutol has largely replaced Para-aminosalicylic acid (PAS) as the second drug. Ethambutol is better accepted by the patient and has fewer side effects. PAS, however, is still recommended in children and pregnant women rather than Ethambutol.

Rifampin, the most recent drug added to the therapeutic armamentarium, now holds great promise. In pulmonary tuberculosis, it has been observed that a six-month course of treatment with a combination of drugs including Rifampin can produce quiescence with a very low relapse rate. The use of this drug in spinal tuberculosis may well change the traditional 18-24 month period of treatment, especially if combined with surgical debridement or spinal fusion. Unfortunately, Rifampin is still quite expensive and is therefore not used routinely in this country except when resistance occurs.

TABLE 2

ACTION AND TOXICITY OF ANTITUBERCULOSIS DRUGS

Drugs	Action	Reaction
Isoniazid	Inhibits DNA synthesis and intermediary metabolism of Microbacterium	Peripheral neuropathy Anemia Allergic reactions/ hepatitis
Aminoglycosides Streptomycin Capreomycin	Inhibits protein synthesis in tubercle bacilli	Eight cranial nerve toxicity Hypersensitivity reactions Nephrotoxicity
Para-amnosalicytic acid	Potentiates effects of INH Inhibits intermediary metabolism	Gastrointestinal influence Allergic reactions
Ethambutol	Inhibits RNA synthesis and phosphate metabolism	Rare visual disturbance (Reduce V.A. and color vision)
Rifampin	Inhibits RNA polymerase	Rare hypersensitivity reaction (thrombocytopenia)

Summary

1. A case of spinal tuberculosis successfully treated with debridement and combined drug therapy is presented.

2. A brief review of the current medical and surgical methods of treatment is given.

3. The recent trend has been toward more agressive surgery to promote faster healing with the least deformity; however, recent studies have shown that healing will occur without surgery, increased kyphosis and prolonged course not withstanding.

4. At present, the recommended treatment is as follows: Combined and prolonged multiple drug therapy in all cases. Debridement only in cases of large abscesses and small bony lesions. Debridement and fusion where large bony lesions exist. Drug therapy alone in developing countries or where surgical facilities are less than optimal.

5. A combination of drugs including Rifampin may shorten the traditional 18-24 months period of drug therapy in the future in skeletal tuberculosis as it has in pulmonary tuberculosis. ■

Acknowledgement

The authors wish to thank Dr. Elmar Kurzbach for referring this patient for treatment and Dr. Robert Wynn for his assistance with the costotransversectomy approach and postoperative management.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE

December 2, 1975

Professional Liability Insurance: The Committee voted to request the Professonal Liability Insurance Committee to develop a contingency plan should malpractice insurance become unavailable or unreasonably expensive in Georgia.

Mental Health Form: On recommendation from the MAG Mental Health Committee, endorsed a new "Mental Health Report" form that had been previously agreed to by Atlanta Blue Cross/Blue Shield. The report form currently in use fails to protect confidential mental health information and had been strongly criticized by MAG members.

Council "Annual Session" Committees: Voted to urge Council to appoint committees composed of Councilors to review annual committee reports that are to go to the House of Delegates. These committees would report back to Council who could then formulate recommendations for or against such committee reports.

Membership Campaign: Received a report describing a massive membership drive among 2,000 Georgia physicians not currently members of MAG.

Appointments: Appointed Carson B. Burgstiner, M.D. of Savannah to the Board of Trustees of the MAG Foundation (Benevolent), Inc., replacing John T. Mauldin, M.D. of Atlanta.

Disciplinary Investigating Committees: Instructed staff to request notification by the Composite Board of Medical Examiners whenever a medical disciplinary investigating committee is appointed in order that headquarters may in turn communicate with the appointees urging their active participation in such investigation.

CALENDAR OF MEETING DATES AND LOCATIONS OF MAG EXECUTIVE COMMITTEE AND COUNCIL

Date	*Meeting*	*Location*
February 14	Finance Committee	MAG Headquarters
February 15	Executive Committee	MAG Headquarters
March 14	Executive Committee	MAG Headquarters
April 8	Executive Committee and Council	Holiday Inn, Jekyll Island
April 9-11	House of Delegates	Holiday Inn, Jekyll Island
April 11	Council Organizational Meeting	Holiday Inn, Jekyll Island
May 16	Executive Committee	MAG Headquarters
June 4	Executive Committee	Pine Isle, Lake Lanier
June 5-6	Council	Pine Isle, Lake Lanier
June 26-30	AMA Annual Meeting	Dallas, Texas
July 11	Executive Committee	MAG Headquarters
August 15	Executive Committee	MAG Headquarters
September 17	Executive Committee	The Cloister, Sea Island
September 18-19	Council	The Cloister, Sea Island
October 17	Executive Committee	MAG Headquarters
November 21	Executive Committee	Omni International, Atlanta
November 19-20	Scientific Assembly	Omni International, Atlanta
December 4-7	Executive Committee, AMA Clinical Meeting	Philadelphia, Pennsylvania

The establishment of this facility at Georgia Baptist Hospital is unique in Georgia.

The Gastrointestinal Diagnostic Unit

DAVID M. TAYLOR, M.D., *Atlanta**

"ONE-HALF OF THE population of the United States has digestive complaints, and one-sixth of all illnesses are in this category. Digestive diseases cause one-third of all deaths from cancer, and is the leading cause for hospitalization and for inability to work because of illness. The estimated economic loss to the nation is 8 billion dollars yearly."[1] This quotation is from the summary statement of "A White Paper by the American Gastroenterological Association" in 1967. Gastrointestinal disease continues to be a major medical problem in our community and country.

In association with this need, there has been developed in recent years a new technology of diagnostic tests which have been proven to be helpful in the evaluation and diagnosis of disease of the digestive tract. These tests will be outlined in this article. In an editorial in *Lancet* in 1974, entitled "Alimentary Endoscopy For All," it was clearly stated that in Great Britain (and America is no different), "it is now time for every area health authority to insure that it has an efficient alimentary-endoscopy service in each of its districts."[2] The scope of the problem is clear and the need for gastrointestinal diagnostic units in medical centers and general hospitals is apparent.[3]

Early in 1974 recommendations were made at Georgia Baptist Hospital, a regional 650-bed hospital catering to all medical and surgical specialties and subspecialties, for the establishment of a gastrointestinal diagnostic unit. These recommendations were carried out and the unit was established in December 1974.

The gastrointestinal diagnostic unit is an institutionally based facility under the direction of a committee comprised of members of both the medical and surgical service. A gastroenterologist is the director with representation from proctology, general surgery and general internal medicine. This committee has met and continues to meet for the solution of problems of location, space, personnel, equipment and procedures.

* Director of the Gastrointestinal Diagnostic Unit at Georgia Baptist Hospital in Atlanta. Dr. Taylor may be contacted for reprints at the Baptist Professional Building, Suite 214, 340 Boulevard, N.E., Atlanta, Ga. 30312.

The unit includes approximately 800 square feet with room for the processing of at least three patients at one time. The staff includes a registered nurse who is trained in gastrointestinal technology. There is also an assistant who is a nurses aide. The procedures being done are summarized in Table 1.

TABLE 1

PROCEDURES BEING DONE IN THE GI DIAGNOSTIC UNIT

Upper Gastrointestinal Panendoscopy, Esophagoscopy, Gastroscopy, Duodenoscopy, including Biopsies and Brushings.[2]
Bernstein Acid Perfusion Test[4]
pH Measurement of Reflux[5]
Esophageal Manometry[6]
Gastric Analysis[7]
Duodenal Drainage[8]
Secretin Test[9]
Small Bowel Biopsy[10]
Proctosigmoidoscopy[11, 12] (Rectal Biopsies)
Colonoscopy (with and without polyp removal)[13, 14]
Peritoneoscopy[15]
Therapeutic procedures like esophageal bouginage, pneumatic dilatation, removal of foreign bodies and dissolution of Bezoars.

Results: The gastrointestinal diagnostic unit has been operational for five months at Georgia Baptist Hospital and the usage of the unit so far has been approximately 500 inpatient procedures and 100 outpatient procedures. Table 2 gives the summary.

TABLE 2

5-MONTH EXPERIENCE—GI DIAGNOSTIC UNIT

	Inpatient	Outpatient	Total
Gastroscopy	133	36	169
Proctoscopy	226	20	246
Colonoscopy	16	—	16
Rectal biopsy	18	4	22
Gastric biopsy	46	18	64
Small bowel biopsy	1	1	2
Bernstein acid perfusion test	15	3	18
Esophageal manometry	13	4	17
Miscellaneous	15	3	18
Total			572

From looking at the figures, proctoscopy is the most commonly used procedure in the unit with gastroscopy second and some of the other procedures, as one might expect, have been done to a lesser degree. One has to keep in mind that many of these procedures have been utilized in this hospital for the first time and their usage should increase with the increased awareness of referring physicians to their availability.

There have been no complications from any of these procedures and the diagnostic value has been felt to be great. Many specific diagnoses, both by functional tests and by biopsy have been made. The financial stability of the unit has been very satisfactory and the hospital administration feels that the unit is self-sustaining.

Discussion

The gastrointestinal diagnostic unit has many functions in a regional and general hospital. In particular, all the various diagnostic studies can be done to help establish a diagnosis. The multiple studies have been shown in the literature and by experience to be valuable when done appropriately. With the establishment of a unit, assistants and technologists can be trained to perform these procedures. In fact, there has been established a Society of Gastrointestinal Assistants which have a newsletter and meetings to keep advised on the newest accomplishments in gastrointestinal diagnostic procedures.[16]

Criteria for physician usage has been established based on local experience, but are in agreement with the editorial from the *Journal of the American Medical Association,* written by Dr. Henry Colcher, President of the Society of Gastrointestinal Endoscopy in 1973.[17] He particularly had reference to endoscopy but his criteria can be true for any gastrointestinal diagnostic procedure. The procedures should be done by: 1) a regular licensed physician who is on the active staff of the hospital; 2) a qualified specialist in the appropriate field, whether this be medicine or surgery; 3) he must be trained in the use of the instruments or in the particular procedure that is being done, and; 4) he should be experienced in the interpretation of what he sees or does. Most importantly, the endoscopist or diagnostician should possess the judgment that will guide him in the selection of the patient to be examined, the safe conduct of the examination, and the utilization of the information obtained. The committee meets and agrees upon every participant in the unit in this manner.

Dissemination of Knowledge

Besides the diagnostic value of the unit, it serves as a central place for the dissemination of knowledge in gastroenterology throughout the hospital. Georgia Baptist Hospital has a residency and intern training program in both internal medicine and general surgery and both services take part in the usage of the unit. It has been found, even in the short time that the unit has been open, that house staff have developed a new awareness, appreciation and knowledge of these techniques, as well as gastrointestinal diseases in general. It has also been clear that the nursing staff, dieticians and ostomy specialists have had a newfound center of activity in the gastrointestinal diagnostic unit.

The professional staff has experienced an increased working together and cooperation. Gastroenterologists, internists, general surgeons and proctologists participate in the running of the unit and the solving of problems and this carries over to mutual understanding and appreciation of each group's strengths and weaknesses.

Clinical research may be easily accomplished in the GI Diagnostic Unit and it is necessary to have an established center for the introduction of new techniques. Certainly, the possibility of the treatment of upper GI bleeding by either laser-induced hemostasis,[18] or electrocoagulation,[19] is an example of one area where technology is developing rapidly and where the GI diagnostic unit will be the area of improvisation and implementation. One could list many other possible advances (and probably many we can hardly conceive of today) where trial and utilization will come through the unit. It is clear that technology is growing rapidly. A recent advance like endoscopic pancreatocholangiography, makes possible what previously seemed impossible. Dr. F. J. Ingelfinger, the editor of the *New England Journal of Medicine,* in an editorial in 1972 using this gastrointestinal diagnostic technique as an example, commented on the need for definitive priorities to be set as to costs and yields.[20] The GI diagnostic unit will be a center for the study of new techniques and their various usages and justifications in the general hospital. It will serve to assuade the concerns of Dr. Ingelfinger and others that techniques may be used indiscriminantly.

Technical changes are here. It is well stated by Dr. Howard Spiro; "Physicians should welcome technology as they recognize that it will change what they do and how they do it much more even than now they can conceive; for technology gives them the chance, if they master it rather than serve at its altar, to return to the real role of the physician."[21] There is no doubt in Dr. Spiro's mind "that technology speeds up practice and improves what is done."[21]

The gastrointestinal diagnostic unit accomplishes in the hospital for physician and patient, a place where diagnosis can be improved, where new tech-

niques can be improved and be studied, where patients can be served and educated, where house staff and physicians can be made aware of progress in gastrointestinal disease, and where complicated diagnostic techniques can be done conveniently, economically and safely.

Summary

Gastrointestinal disease is a major economic and health problem in the United States. In recent years there has been a great increase in the procedures available for definitive diagnosis of gastrointestinal disease. A gastrointestinal diagnostic unit has been set up in a regional hospital in Atlanta, Georgia, and has successfully accomplished over 600 procedures in five months with efficiency, value of diagnosis and safety. It is felt that this type of gastrointestinal diagnostic unit serves physician, patient and community alike. ■

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STUDY CAUTIONS AGAINST TRAINING TOO MANY PHYSICIAN EXTENDERS

Training large numbers of physician extenders (PEs) may not be the answer to alleviating physician shortages, a recently published report from InterStudy reveals. The report evaluates research literature on the use of physician extenders to increase the supply of medical services. It concludes: "Such policy could be implemented and may prove successful, but implementation comes at a risk of both increasing services in areas where they are already abundant and of producing an oversupply of PEs—possibilities which would prove costly in monetary as well as human terms."

Physician extender refers to four groups—the physician's assistant, the Medex, the nurse practitioner, and the Primex. Widespread training of PEs began in the 1970s as a result of their promise, in concept at least, to relieve physician shortages in some locations and in primary care by providing certain medical services through less highly trained and lower-paid persons.

According to the report, evidence shows that by using a PE, small practices can increase the amount of medical services provided by 10 to 40 per cent. The research reviewed also shows that the care delivered by PEs is of high quality. "There is no evidence of inferior diagnosis or treatment, or deteriorating health status among patients served by PEs. Attitudes of both patients and physicians associated with PEs are overwhelmingly favorable," the report says.

The most important unanswered question regarding the role of PEs in substantially increasing medical services, according to the study, is whether there is a limit on the number of PEs the health care system will demand. The report recommends that for some time to come we train only enough PEs to meet a predetermined demand or that we train a conservative number of PEs while continually monitoring their labor market.

Physician Extenders: An Evaluation of Policy-Related Research reviews the literature on PEs' quality, productivity, numbers today and projected numbers to 1980, demand, geographic distribution, and the proportion of PEs delivering primary care. It is one of four reports InterStudy is issuing under a National Science Foundation project to evaluate policy related research on the effectiveness of alternative allocation of health manpower.

The other papers in the series address foreign medical graduates, group practice, and the geographic distribution of physicians. *Physician Extenders* is available from InterStudy's Library, 123 East Grant St., Minneapolis, Mn. 55403, for $9.50. An appendix to the report can be obtained for an additional $9.50.

A "Pseudotumor" of the Stomach

VAN COLEMAN, M.D. *and* M. FUJIOKA, M.D., *Atlanta**

DR. VAN COLEMAN: This is the case of a 72-year-old female with several months history of intermittent diffuse abdominal pain. There has been a 15 pound weight loss in the past year; the patient had no specific gastrointestinal complaints.

These are representative films of a routine upper G.I. study with multiple spot films (Figure I).

Dr. Mutsuhisa Fujioka: There is obvious increased distance between the left diaphragm and the lumen of the gastric fundus which is outlined by barium and there are multiple nodular filling defects in the region of the fundus. The multiple films demonstrate variable distention of this area of the stomach indicating that is is flexible. It is very important to distend the gastric fundus for evaluation of lesions in this area with gas or barium.

As far as this study is concerned, one can see the constant multiple filling defects within the fundus which seem to extend along both the lesser and greater curvatures of the gastric body. In addition to this, there are some niche-like protrusions within several of the filling defects.

From this examination, one can only give a differential diagnosis for nodular lesions involving the fundus. Among the intragastric tumors, statistically the lymphoma group is the most common because of multiplicity, nodularity and central ulcerations.

However, it is said that the nodular type of malignant lymphoma tends to be seen in the distal stomach, whereas the diffuse prominent gastric rugal infiltrative type is more often seen in the fundus.

Multiple leiomyomata or even multi-centric gastric carcinoma is still highly possible for this appearance. Although the central ulceration is not characteristic, one should consider the possibility of other intramural submucosal tumors, such as neurofibroma, eosinophilic granuloma, or lipoma. Very rarely inflammatory lesions such as Menetrier's disease or pancreatitis may show some similar changes due to hypertrophic or edematous changes of the gastric mucosa. Multiple defects such as are demonstrated here may very rarely represent extragastric disorders, with extrinsic compression.



FIGURE 1

Oblique film of the stomach demonstrating irregular defects along the greater curvature of the fundus and proximal body of the stomach.

Dr. Coleman: What procedures would you recommend for further study of this lesion?

Dr. Fujioka: As with any intraluminal or intramural mass lesion of the intestinal tract, it is advisable for a repeat examination to be carried out at a later date to confirm that the lesion is consistently present. In Japan, we would routinely perform a more sophisticated technique of double contrast examination of the stomach, using a nasogastric tube or gas-producing powder and anticholinergic drugs to reduce the gastric hypertonicity to confirm the diagnosis. Then we would prefer to use the endoscopic examination as the next step in evaluating the lesion.

Most radiologists in Japan are familiar with the endoscopic examination, which is a very accurate study to evaluate especially lesions along the lesser

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Drs. J. L. Clements and H. S. Weens.

curvature and the gastric angle, but sometimes insufficient to evaluate the superior aspect of the fundus, because of technical difficulties. The prepyloric region is also difficult to evaluate because of peristaltic motion which may simulate the pyloric canal. Even with the use of the modern flexible endoscope with good technique these areas are difficult to evaluate.

Dr. Coleman: A repeat barium contrast examination of the stomach was not carried out. The patient underwent gastroscopy which revealed the gastric mucosa to appear intact. There was a defect along the proximal greater curvature which was thought to be extrinsic in nature. Cytological studies were reported as suspicious for neoplasm. Because of the suspicious cytology the patient underwent abdominal exploration.

At surgery, the stomach had a normal appearance, there was no evidence of intrinsic or extrinsic mass lesion to account for the lesion seen on gastrointestinal study.

Discussion

The gastric cardia and fundus are well known for their ability to harbor mass lesions. The nature of such lesions is often difficult to ascertain radiographically because of their similiar presentations and the limitations of the upper gastrointestinal examination. Therefore, various benign lesions may mimic malignant tumors, and extrinsic masses or compression by adjacent anatomic structures may simulate intrinsic gastric tumors. Finally, as in the present case, there are "masses" seen on upper gastrointestinal tract studies, but which are not confirmed subsequently, so-called pseudotumors.

The incidence of gastric pseudotumor is higher in those patients with hiatal hernias and in those with postoperative distortion of normal anatomic relationships. The diagnosis is necessarily one of exclusion of a true pathologic process and may require a varity of confirmatory procedures such as repeat barium studies, vascular studies, radioisotope scanning, and endoscopy. Despite all of these studies, ultimately a laparotomy will be necessitated in a certain percentage of these patients for definitive diagnosis. ■

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OPPORTUNITIES FOR CONTINUING MEDICAL EDUCATION

AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY
Tenth Annual Meeting and Scientific Assembly
February 29-March 5, 1976
Americana Hotel, Bal Harbour, Fla.
Contact: John G. Bellows, M.D., Ph.D., Director, 30 N. Michigan Ave., Chicago, Ill. 60602

SOUTH CAROLINA INTERNAL MEDICINE SPECIALISTS
March 5-6, 1976
Myrtle Beach Hilton, Myrtle Beach, S.C.
Contact: Stephen T. Donehue, 420 Lexington Ave., Suite 443, New York, N.Y. 10017

UROLOGY SEMINAR ON UROLOGIC SURGERY
Emory University
March 3-6, 1975
Marriott Motor Hotel, Atlanta

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION
March 3-7, 1976
Peachtree Plaza Hotel, Atlanta
Contact: M. F. Langer, Ph.D., 1775 Broadway, New York, N.Y. 10019

POSTGRADUATE SEMINAR IN UROLOGY
American Urological Association
March 5-7, 1976
Atlanta

ATLANTA GRADUATE MEDICAL ASSEMBLY
March 14-17, 1976
Omni International Hotel, Atlanta
Contact: Winnie Hopkins, 875 W. Peachtree St., N.E., Atlanta 30309

SOCIETY OF TOXICOLOGY
March 14-18, 1976
Marriott Motor Hotel, Atlanta
Contact: G. C. Boxill, Ph.D., Wyeth Laboratories, Box 861, Paoli, Pa. 19301

THE SOUTHEASTERN SURGICAL CONGRESS
44th Annual Assembly
March 14-18, 1976
Marriott Hotel, New Orleans, La.
Contact: A. H. Letton, M.D., 315 Boulevard, N.E., Atlanta 30312

FOURTH ANNUAL POSTGRADUATE SEMINAR IN EMERGENCY MEDICINE
Florida Chapter, American College of Emergency Physicians
March 19-22, 1976
Americana Hotel, Miami Beach, Fla.
Contact: Registrar, 1976 PGS, 1919 Beachway Road, Suite 5-C, Jacksonville, Fla. 32207

FOURTH ANNUAL CONFERENCE ON PERINATAL MEDICINE
March 24-25, 1976
Callaway Gardens, Pine Mountain
Contact: Micki Souma, M.D., Perinatology Dept., The Medical Center, Columbus 31901

A First for MAG

A DECLINING ATTENDANCE at the scientific presentations, a declining quality of these presentations, and a rising significance of socio-economic and political considerations caused the House of Delegates of MAG, in the spring of 1973, to recommend study of the possible separation of the business and scientific aspects of the MAG annual meeting into two separate and distinct entities. A planning committee was formed, and the ultimate result was our recent first Scientific Assembly held at the Terrace Garden Inn in Atlanta November 21 and 22.

Serving As An Umbrella

After long consideration as to how MAG should best enter the crowded arena of continuing education, it was decided that the state association should serve as an umbrella and sponsoring agency under which the state specialty organizations could rally and plan meetings of special interest and benefit to their members. With considerable insecurity, we surveyed these specialty groups and found 12 willing to proceed with planning for a Scientific Assembly. We were overwhelmed with the response, as over 300 physicians attended the various sessions and commented enthusiastically about their personal educational gains and about the concept of this type of venture by MAG. The programs presented by these 12 organizations offered a veritable smorgasbord of educational opportunities from which physicians could choose. Educational programs were also offered for the physician's spouse, who also had an excellent opportunity to have receptions, and in general everyone was kept quite busy.

Scientific offerings by the various organizations were varied. The American





Above: Featured luncheon speaker Anne R. Somers is joined at the head table by planning Committee members Nicholas E. Davies, M.D. (L) and LaMar S. McGinnis, M.D., Chairman. Right: A session planned especially for spouses features a question and answer session with Atlanta psychiatrist Alfred A. Messer, M.D. (R) and G. Douglas Talbott, M.D., medical director of the DeKalb Alcohol and Drug Programs.



Georgia's First Lady Mrs. George D. Busbee (R) joins Auxiliary President Mrs. Phil Astin of Carrollton for the opening luncheon of the first Scientific Assembly.



Special guest of the American College of Physicians, meeting in conjunction with the Scientific Assembly, is George W. Pedigo, M.D. (L) of Louisville, Kentucky, regent of the ACP. His host is Edwin C. Evans, M.D. of Atlanta, Governor for Georgia of the ACP.

College of Physicians presented a most extensive program utilizing a full day and a half. As part of its program, the American College of Surgeons sponsored a competition between selected surgical residents from over the state. The plastic surgeons devoted an afternoon to the study of breast reconstruction; the gastroenterologists met with the surgeons to discuss endoscopy; the chest physicians offered an excellent program with an outstanding guest faculty on the immunological aspects of pulmonary disease; and the pathologists, radiologists, neurologists, neurosurgeons, and ophthalmologists all attracted sizeable and enthusiastic groups to their meetings.

Questions to Consider

The MAG House of Delegates must decide this spring if we should continue on this course. How should we finance such meetings? Should we expand the scope? Should we offer true postgraduate education with formal course, a syllabus, and a faculty? Should we continue to work as an umbrella for the specialty societies? Should we, in cooperation with the Atlanta Graduate Medical Assembly, offer an expanded educational opportunity in the fall and early spring on an annual basis?

Continuing education is like mother and apple pie. The concept is always viable to the professional as he tries to sort out the questions: Where am I going? How shall I get there? How will I know when I have arrived? We recognize that the heart of continuing education programs must reside locally in a community hospital and with the individual physician and his own method of "keeping up." However, we believe that there is a definite place for a Scientific Assembly, sponsored by the Medical Association of Georgia. Our beginning was auspicious, and the umbrella concept for the specialty society activities was enthusiastically received. We recommend a continuation of this MAG activity; and in the event that the House of Delegates agrees, reservations for November 19 and 20, 1976 have been made in the specatacular new Omni International Hotel.

LaMar S. McGinnis, Jr., M.D.
Chairman, Planning Committee
365 Winn Way
Decatur, Georgia 30030

MAGNET '75: A Review

THE 1975 MAGNET Conference, using the broad theme of "The Future of Medical Practice," focused on several topics of interest to physicians and their advisors and aides. Over 130 people attended the sessions in late November at the Terrace Garden Inn in Atlanta.

The Saturday session directed attention to the practice side of the physician's life with discussions on resolving Medicaid and Medicare claims problems, professional liability insurance and health services agencies. Of particular interest was the talk on professional liability, given by Mr. Leyton B. Hunter, president of the London Agency in Atlanta. Mr. Hunter's firm is responsible for setting up the Florida Medical Association's professional liability trust plan.

The Medicaid and Medicare discussions centered on the most common reasons for delayed or returned claims. John Voigt of the Georgia Medical Care Foundation gave the Medicaid talk with Medicare being addressed by Ted Snyder of the Prudential Insurance Company.

Sunday sessions related to the more personal side of the physicians' life. Topics covered were the more effective use of banking services, estate planning, the 1974 pension reform act.

The MAGNET '75 program coordinator was Marvyn D. Cohen, M.D. of Columbus. Dr. Cohen is also chairman of the MAG Communications Committee.

The MAGNET Conference program has been accepted for seven elective hours by the American Academy of Family Physicians.

Plans are now underway for the 1976 conference with dates and location to be announced by the Communications Committee shortly after the first of the year.





Above: Conference speakers John Voigt (L) and Ted Snyder (R), flanking MAGNET coordinator Marvyn D. Cohen, M.D., review Medicare and Medicaid problems. Right: Leyton B. Hunter of the London Agency advises physicians to avoid malpractice claim judgments against them by keeping good records, not guaranteeing cures, informing of risks and avoiding patient abandonment.

Letters to the Editor

Dear Sir:

In the January '76 session of the Georgia General Assembly a bill will be introduced to change Georgia's old adoption code enacted in 1941. This new bill has been drawn up with the cooperative efforts of representatives from the Georgia Department of Human Resources, the Attorney General's office, the Georgia Bar Association, the Georgia Academy of Obstetrics, the Georgia Academy of Pediatrics, and a private adoption agency. This bill is designed to insure the rights of the child, the adoptive parents, the natural parents and also to help control black market adoptions and other abuses in the adoptive procedures.

In my years of practice I have seen several abuses of adoption. One naive, gentle couple actually had a second adoptive child forced on them by the lawyer involved. At the time the adoptive mother's health was poor, their financial position was poor and these parents were having behavior problems with their first adopted child. Certainly their position at that time did not dictate another adoption. If this couple had proper counseling the adoption would have been postponed.

It is interesting that this month's (December '75) issue of the *Journal of Pediatrics* has an article on the problems of psychological adjustment of the adopted child. The author describes early good adjustment but many problems arising in the middle years of childhood with questions about their own identity wanting to know something of the biological parents. The author suggests that the child must have a realistic picture of the original parents in order to handle their own problems of identity. This report rings true with our experiences at the agency. Many times early adolescents and older children come to the agency and receive help establishing "who they are." This is accomplished through the careful records which the agency maintains.

This new adoption bill will require that private placements will take place only after the natural parents' rights have been terminated in a juvenile court proceeding. This will help avoid the anguish which recent sensational newspaper accounts have described, with the natural mother coming back years after adoption and fighting in the courts for her child.

The new bill also requires that the adoptive parents provide to the court a report of all money spent in connection with the adoption. This will prevent the natural mother from selling the baby as in a black market adoption. It will also cut down on exorbitant fee abuses by attorneys.

Lastly the bill will establish a procedure for notifying the natural father of his rights as has been required by recent Supreme Court decisions.

This bill is welcomed by all people interested in safeguarding adoption practice. We feel it will benefit the child, the biological parents, and the adoptive parents. I urge your support of the bill.

Joseph A. Snitzer, III, M.D.
3162 Piedmont Road, N.E.
Atlanta, Georgia 30305

(Dr. Joseph Snitzer is a pediatrician in Atlanta who has been pediatric consultant to a private Atlanta adoption agency for nine years. He is presently chairman of the Legislative Committee of the Georgia Academy of Pediatrics and president of the Greater Atlanta Pediatric Society.)

Dear Sir:

I feel that I would be derelict in my duty if I did not comment on the Physician's Assistants' Program article appearing in the October 1975 issue of the MAG.

I was Chief of Staff at the University Hospital when an attempt was made to integrate this program into the medical education system at the University Hospital.

The program was rejected on the basis of what our Executive Committee felt were serious weaknesses inherent in the implementation of the program.

We felt that it was not born out of sound medical reasoning and had been fostered politically in Augusta, and politically prior to reaching Augusta.

The article appearing in the *Journal* presents a Utopic principle but is so full of improbabilities as to make it a potentially dangerous set of circumstances.

The article states that a physician's assistant will be able to ascertain if an organ system is normal, abnormal or equivocal. Most of us with any experience know that this is a monumental task even in the best of hands, and certainly, a partly-trained individual cannot be trusted to even approach this opinion. Also, to feel that a PA could be upgraded to a point that "the physician would simply be informed that a particular case had been handled in this prescribed manner" will open a floodgate of medical and legal woes. A PA working with a physician is going to sooner or later run into the combination of circumstances where an overworked, worn-out or fatigued physician is going to delegate too much authority to the PA, who is going to readily take it, and the cycle of errors will begin.

The human body is a forgiving machine and to some degree, as we all know, allows a certain degree of success even among the cultists. The errors of a PA will take advantage of this fact with diminishing returns as he gets more and more authority, either

politically or by delegation, from overworked physicians.

I guess you might say that, in essence, it is better for a certain segment of the public to be under the surveillance of one well-trained physician, even with some of the inconveniences, than to dilute the quality of this physician by any means. The traditional role of doctor and nurse can be slowly expanded to cover the population increase in a much more efficient manner than interposing a middleman who has neither qualification.

Lastly, the malpractice situation is bad enough at the present but I do not think it takes much vision to realize what will happen if this program becomes widespread.

Sincerely yours,
Pomeroy Nichols, M.D.
Neurosurgical Associates, P.A.
University Medical Court
1521 Pope Avenue
Augusta, Georgia 30904

GEORGIA MEDICAL CARE FOUNDATION STUDY COMMISSION

D. R. MAHAN, M.D., *Chairman, Dalton*

The Study Commission of the Georgia Medical Care Foundation is the result of a concern on the part of the Medical Association of Georgia for effective and efficient direction in the administration of the health care delivery system in Georgia. The Commission was created in May 1975 by the Foundation as a result of a report adopted by Council at its meeting the previous month and initially it was intended to study the question of the Medicaid Program in Georgia. After some initial work, however, it quickly became apparent to the members of the Commission that to limit its attentions to the Medicaid Program would be to ignore the larger part of the issue. Medicaid is inextricably woven into an administrative fabric that overlays all health services provided in a state and it would be impossible to study and make recommendations with regard to this single program without considering the others. Moreover, to concentrate on this narrow field would be to ignore changes likely to be caused by the adoption of national health insurance.

The proposed study is, to our knowledge, unique in that is represents the first time that physicians and other health providers have demonstrated an interest in evaluating the entire health system and making realistic observations and recommendations for change. While the undertaking of such a task is obviously a long range project, we do feel that it will be possible to come up with some immediate recommendations for some short range solutions to the most pressing of our problems in the Medicaid program, while working on more lasting recommendations.

The general format of the study will involve study teams—composed of representatives of the various health care provider groups, third-party carriers, and even consumer representatives—identifying all the significant components in the system, inter-relationships between these components, the problems arising out of these inter-relationships, and the identification of means of solving or alleviating these problems. More simply stated, we are going to look for a way to eliminate the duplication, overlap, contradiction, and inconsistency between the various components with whom providers of medical and other health services must deal.

It is the feeling of the Foundation, and of the Council, that such a study should be undertaken and should be conducted under the umbrella of the Medical Association of Georgia, with physicians responsible for its direction and outcome. All in all, this study represents a very positive step on the part of your Medical Association and Foundation to deal with the problems in the State of Georgia, and I hope to be able to report to you periodically on the progress of this study.

Enterostomal Therapy in Georgia

DEBRA C. BROADWELL, R.N., M.N., E.T., *Atlanta**

A NEW NURSING subspecialty, enterostomal therapy, has been developing in Georgia over the past few years. The pioneers of enterostomal therapy, with support from patients, surgeons, and community groups, banded together to share and develop the limited knowledge and limited supplies of those early years. As surgical and diagnostic techniques advanced there was an overwhelming increase in the numbers of ostomates. Simultaneously, nursing, as a profession, was developing into a distinct field of care.

Enterostomal therapy began as a method of providing physical management of the stoma for the ostomy patient. Now, enterostomal therapy (as a nursing subspecialty) involves not only the rehabilitation of patients with fecal or urinary abdominal stomas, but encompasses other areas of patient care. Management of skin care for all patients is a role of the hospital-based enterostomal therapist. Existing decubitus ulcers, draining wounds and various types of fistulas are cared for by the enterostomal therapist. Equipment, pouches and skin barriers was the limited area in which the enterostomal therapist functioned. This is not to say that equipment is not important in the care of patients, but enterostomal therapy has grown to include many other areas. Lenneberg (*Cancer,* September 1974, p. 980) makes a distinction between teaching self-management and long-range rehabilitation: "The most urgent business of the postoperative patient is to learn how to cope with the effluent from the stoma. Only after this matter has been resolved can one turn the patient's attention to issues that may arise in the future."

Patient Education

The enterostomal therapist begins patient education during the first (hopefully preoperative) visit and at the same time assesses the patient and his family in order to establish written objectives to meet the overall goal of rehabilitation. The enterostomal therapist establishes a written plan of care which includes the equipment chosen for that patient, a systematic approach for teaching the patient to change his pouch, information concerning possible complications (skin irritations, obstructions), home remedies, and guidelines for contacting medical personnel.

Not only is patient and family education important for the enterostomal therapist, but education for nursing staff and doctors and provisions for communications between patient, nurse, doctor and enterostomal therapist is of upmost importance. The patient is a vital member of the health team. All plans must be geared to the patient and his needs throughout the rehabilitation process. Rehabilitation begins prior to surgery and may not be completed for many months after discharge. Most enterostomal therapists see patients routinely after hospitalization until both patient and enterostomal therapist are satisfied with the progress the patient has made.

One of the 10 training schools of Enterostomal Therapy is located at Emory

* Emory University Enterostomal Therapy Training Program, Emory University Clinic, Atlanta, Ga. 30322. William C. McGarity, M.D. is director of the program, and the faculty includes Ms. Broadwell, Jane Walter, E.T. and Suzanne Sorrells, R.N., B.S.N., E.T. Prepared at the request of the Professional Education Committee of the Georgia Division, American Cancer Society.

University. The school offers five six-week courses each year. Six registered nurses are accepted in each session.

The program covers anatomy and physiology, fluid and electrolytes, psychosocial and sexual adaptations, available products, and development of inservice education as related to the ostomy patient. Clinical experience includes 240 hours at a 1,500 bed city-county hospital, a 500 bed private hospital, a children's hospital, and an out-patient clinic. The graduates of the Emory University Enterostomal Therapy Training Program are certified by the International Association for Enterostomal Therapy.

February Seminar Scheduled

On February 27, 1976, an eight-hour ostomy seminar for R.N.'s, L.P.N.'s and student nurses will be held at the Terrace Garden Inn on Lenox Road in Atlanta from 8 a.m. to 5 p.m. C.E.U. credits will be offered to participants. The program will cover the psychosocial and sexual adaptation of ostomy patients, indications for surgery, and four rotating workshops on colostomy care, ileostomy care, urinary diversions, and management of fistulas and draining wounds. All participants will have the opportunity to attend each workshop. The programs are being presented by William C. McGarity, M.D., chief of surgery for Emory University Hospital and director of Enterostomal Therapy Training Program, Emory University; Sylvia Sultanfaus, R.N., M.S.N., mental health consultant at Emory University Hospital; Francis Nagata, R.N., M.S.N., director of counseling and training, Counseling and Sexual Enrichment Center of Atlanta; and workshops will be presented by board members of the International Association for Enterostomal Therapy. For registration blanks please write: Linda Priest, Third Floor, Emory University Clinic, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

The American Cancer Society, Georgia Division, has long played an active role in the development of the enterostomal therapy program in Georgia. For a number of years a consultant was paid by the Georgia Division, ACS, to aid in the development of an ostomy program in Georgia, which ultimately led to the inclusion of a program at Emory University for the training of enterostomal therapists. Grants were made for three years by the national American Cancer Society to support this training program that is one of 10 such programs in the country. The National Cancer Institute now provides the support for this training facility at Emory. Further information about this program may be obtained by writing to Linda Priest as indicated above. ■

IMPORTANT NOTICE FOR PHYSICIAN'S RECOGNITION AWARD APPLICANTS

Printed in the August, 1975, issue of the *Journal* was a yellow form for the physician to keep an ongoing record of his or her continuing education. This form may be used *as the physician's application* for the AMA's Physician's Recognition Award. However, since the printing of the form there has been a change in the AMA's policy on the application fee for the award. Beginning January 1, 1976, AMA members will *not* be required to pay an application fee, whereas the fee for non-members of the AMA will be increased to $25.00.

Atrial Septal Defect

REVIEW OF TEN YEAR EXPERIENCE

J. I. MILLER, M.D., A. B. SAMS, P.A. *and*
C. R. HATCHER, JR., M.D., *Atlanta**

ATRIAL SEPTAL DEFECT is one of the most common congenital cardiac anomalies and is the most common congenital cardiac lesion seen in the adult. A brief summary of the symptoms, pathology, surgical repair, and complications presented by patients with this type of lesion will be discussed with particular emphasis on the adult patient with atrial septal defect. The basis of this report is our experience with 218 patients with atrial septal defect.

The anatomic types of atrial septal defect and their frequency of distribution are as follows: ostium secundum defects, 83 per cent; sinus venosus defects, 9.6 per cent; ostium primum defects, 7.4 per cent; and complete atrioventricular canals, less than 1 per cent. Atrial septal defect may frequently be associated with other congenital cardiac lesions such as partial anomalous pulmonary venous drainage, pulmonic stenosis, mitral stenosis, persistent left superior vena cava, and, rarely, mitral insufficiency.

The lesion is more common in females than males with a ratio of 2.5 to 1. The majority of patients with atrial septal defect present between the ages of 2 months to 65 years with a mean age of 17.5 years at the time of surgical repair. Approximately one-third of patients with atrial septal defect are asymptomatic and two-thirds are symptomatic. The most common symptoms are those of congestive heart failure, shortness of breath, dyspnea on exertion, and fatigability. Growth retardation, palpitation, cyanosis, chest pain, and syncope are much less common.

The most commonly noted abnormalities on the electrocardiogram are right bundle branch block, 82.3 per cent; right axis deviation, 47.8 per cent; and right ventricular hypertrophy, 54.3 per cent. Approximately 8 per cent have atrial fibrillation preoperatively. The majority of ostium primum defects will be characterized by a counterclockwise loop in the horizontal plane on the vectorcardiogram.

The predominant chest roentgenographic findings are right ventricular hypertrophy and right atrial hypertrophy. The majority of patients will have an increase in the size of the main pulmonary artery, and there will be evidence of increased pulmonary flow in 75 per cent of patients.

At cardiac catheterization, the majority of patients will have evidence of a left to right shunt with a pulmonary flow to systemic flow ratio of 2.1 to 4.1. Approximately 25 per cent of patients will have evidence of pulmonary hypertension. In the adult patient with atrial septal defect, 50 per cent will have evidence of pulmonary hypertension.

The preferred method of repair is with the utilization of cardiopulmonary bypass with either direct closure or synthetic patch closure of the defect as dictated

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Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

by its size. Concomitant correction of associated congenital or acquired cardiac abnormalities can be carried out at the same time without an increased risk of morbidity or mortality. Fifty per cent of adult patients will require synthetic patch repair of their atrial septal defect.

In a recent review of 218 patients undergoing surgical repair of arial septal defect during the last 10 years, there were 74 patients greater than 30 years of age. The anatomic distribution, electrocardiographic findings, chest roentgenographic findings, cardiac catheterization findings, and symptomatology were essentially the same as those of the group as a whole. A larger percentage of patients with adult atrial septal defect have atrial fibrillation preoperatively (16 per cent) as compared with all patients undergoing repair.

The results of surgical treatment in this group of 218 patients revealed an overall hospital mortality of 2.7 per cent with only one death in the past five years. There were six hospital deaths and one late death in the follow-up period of six months to 10 years with a mean follow-up of 4.3 years. Of the hospital deaths, two occurred in patients less than 30 years of age, and four occurred in patients greater than 30 years of age. The one late death occurred in the adult group. The predominant nonfatal complications involved in patients undergoing repair of an atrial septal defect are postoperative pericarditis, pneumonitis, atrial arrhythmias, and, in older patients, pulmonary embolism. Approximately 38 per cent of all patients undergoing repair of atrial septal defect will develop significant atrial arrhythmias in the postoperative state. The frequency with which these arrhythmias were seen is as follows: atrial flutter or fibrillation, 9 per cent; paroxymal atrial tachycardia, 4.7 per cent; transient atrioventricular dissociation, 17.2 per cent; transient complete heart block, 3 per cent; and atrial bigeminy, 2 per cent. Late complications are rare, and the majority of patients undergoing surgical repair can expect long term improvement. Follow-up was obtained in 200 of our 218 patients. All surviving patients are symptomatically improved with 90 per cent in New York Heart Association Class I and 10 per cent in New York Heart Association Class II.

Significant Improvement for Adults

While there has been controversy in the literature about the increased risk of surgery in patients greater than 40 years of age with atrial septal defect, our data would support the thesis that the adult patient can be operated upon with low risk and can expect significant functional improvement following surgical repair. Eighty-five per cent of our adult group had significant symptoms, and a large number had both symptoms of congestive heart failure (50 per cent) and pulmonary hypertension (50 per cent). The majority of patients in the adult group preoperatively were in New York Heart Association Class III. In long term follow-up all surviving adult patients are in New York Heart Association Class I or II. Increased age, symptoms of congestive heart failure, and an increased incidence of pulmonary hypertension in the adult group did not result in a significantly higher morbidity or mortality.

In summary, this report details the spectrum of atrial septal defect in terms of anatomic type, symptomatology, electrocardiographic findings, chest roentgenographic findings, and surgical repair. In a review of 218 patients, there was an overall hospital mortality of 2.7 per cent with only one death in the past five years. These figures would indicate that all patients with atrial septal defect can undergo surgical repair with a low mortality and expect significant improvement in their symptoms. There appears to be no increased risk in the adult patient with atrial septal defect, and the factors of increasing age, symptoms of congestive heart failure, and pulmonary hypertension do not adversely affect surgical morbidity or mortality. ■

Informed Consent and Res Ipsa Loquitur

J. WINSTON HUFF, *Atlanta**

MUCH HAS BEEN WRITTEN about the doctrines of "Informed Consent" and *"Res Ipsa Loquitur"* as bases for claiming liability against physicians. It is the intent of this brief article to discuss these doctrines as they now apply in Georgia.

Informed Consent

In days gone by in this State a medical procedure practiced on a patient without his consent was considered an "assault and battery"; in other words, a physical injury inflicted without the other person's consent. Several horror cases appear in the reports of the Georgia appellate courts. There was one case in which a physician promised the patient's father that he would not operate on the son's hip. However, he did go ahead and operate on the hip with a crippling result. Recovery was allowed against the physician on the basis of assault and battery.

In another case, a doctor became angry at a patient upon whom he had performed an appendectomy a few months before. Under the guise of examining the condition of the incision he strapped her to a table and performed an operation cutting the arm off of the unborn child she was carrying.

The more recent application of "informed consent" has been confined to much more subtle situations. Here the doctrine refers to giving as complete as possible information to the patient of the procedure to be performed and its possible risks. Courts in other states have stated that a patient has the right of self determination of whether he shall receive non-emergency care. Thus, even though a thorough examination is conducted and proper medical judgment is exercised in the decision as to the procedure to be performed, the patient has the right to be informed and make his own appraisal of the benefits and risks before he consents. The idea is that he cannot validly consent unless he fully knows the facts. Thus the malpractice, if any, is not generally in the way the procedure was performed, but in failing to inform the patient fully of the attendant hazards.

Fortunately, the Georgia courts have not yet gone this far and, indeed, have not definitely adopted the "informed consent rule."

> "Briefly stated this rule is that a consent to a treatment or diagnostic test obtained without the disclosure of the hazards or dangers involved is no consent. Whether or not the 'informed consent' rule is applicable in this state, such rule, if applicable, applies only to the duty to warn of the hazards of a correct and proper procedure of diagnosis or treatment and has no relation to the failure to inform of the hazards of an improper procedure."[1]

As late as September of this year the Georgia Court of Appeals held that in

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such cases the possibility of risk must be proved by another physician.

> "Appellant produced no expert testimony as to whether permanent hoarseness was a known occurrence of the present procedure, performed in a proper manner. This is not a matter which jurors would know by reason of common knowledge, but it is one concerning highly specialized expert knowledge, requiring expert testimony. 'Whether the defendant was negligent or acted in an ordinarily skillful manner as a physician . . . in advising the husband of the risks involved in treatment and obtaining his consent for treatment, including surgery . . . depends ultimately on the evaluation of expert medical opinions. . . .'
>
> "The 'informed consent rule,' if applicable in this State, requires that the plaintiff establish by expert testimony that the hazard is a known complication of the procedure involved."[2]

One additional fact in favor of the Georgia doctor is the Georgia Medical Consent Law which has been in effect for several years and which sets forth who may consent to a medical procedure.

This law also states that a consent which discloses in general terms the treatment in connection with which it is given and which is evidenced in writing signed by the patient or another person authorized to sign for the patient is conclusively presumed to be a valid consent in the absence of misrepresentation of a material fact. There has been no court interpretation of this statute but it does appear to offer the physician additional protection in this area.

Res Ipsa Loquitor

Finally, you may have heard of still another theory of physician liability. This is "res ipsa loquitur" or "the thing speaks for itself." It is an old doctrine of personal injury law which says that the very fact that the injury occurred shows that something must have gone wrong. A jury in such a case is authorized to infer that there is negligence even though there is no direct proof of it. This rule has been used in a few other states to hold a physician liable. The Georgia Court of Appeals has ruled in a suit against a dentist that the rule does not apply in malpractice cases.[3] Also, the United States Circuit Court of Appeals for the Fifth Judicial Circuit (in which Georgia is located) has held that the rule is inapplicable to medical malpractice cases in this state.[4] ■

REFERENCES

1. Ga. Code Annotated §84-924.
2. Pierce v. Dowman, Ga. Court of Appeals, decided Sept. 3, 1975.
3. Wimpy v. Rogers, 58 Ga. App. 67.
4. Starr v. Fregosi, 370 F.2d 15.

I've told this before

(Ed. note: A series of improbable circumstances results in an unfortunate consequence for the fisherman in this tale by J. G. McDaniel, M.D. of Atlanta. Stories are solicited from MAG members and their families and should be submitted to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Killer Fish

It was during the 1st World War, I do not remember the year because I was a teenager then, but I do remember a man, I think, by the name of Rembrant Bowen. They called him "Rem." He was from Rhine, Georgia and prided himself as the best carp fisherman on the Ocmulgee River.

On this particular Saturday afternoon, he brought in a giant carp that he had caught just after daylight. Fishermen and friends in Rhine told him that very few would believe him unless he took it to Eastman, which was 16 miles away, and had it weighed at Coleman's hardware store. They did this because ole man Coleman had never been known to tell a lie about the weight of a fish.

The fish weighed 30 pounds. Citizens old and young, black and white, looked at him and shook their heads in disbelief and asked "Rem" all sorts of questions. He explained over and over about the stout cane pole, the big bronze hook, the 60 pound test line, the special cornbread mix that his wife made so that he could mold it around his hook. The only thing he wouldn't tell them was the exact place on the river where he caught him.

There was a man standing in the back of the crowd by the name of Will Lowery and while he said nothing, he kept perusing the fish with intense interest. After a little while he went up and looked carefully at his mouth, which was relatively small and bent down from his head in a funnel shape. There was a long scar which extended from just below his eye to his lip on the right side and his lip had an indentation in it, as though he had a hare lip.

Will turned to interested onlookers and said, "I know this fish. I've seen him before. In fact, I've had my hands on him." Everybody looked at him in disbelief. With very little prodding, he told the following story:

"Two years ago there was a tenant farmer who lived out on the Wilcox place, which was 10 miles away and near the Ocmulgee River. His name was Joshua Jones. Josh was one of the best hands up and down the river. He and his wife and children worked hard. He never got into trouble with the law. He'd do what he said he was going to do and was trusted and respected by one and all along the river.

"Josh loved to fish and provided much food for his family in the form of catfish, carp and perch, but he never fished when there was work to be done on the farm.

"On this Friday afternoon in the fall, cotton and corn were still being harvested, but it had rained all night on Thursday and into the morning. Along about 11 o'clock the clouds began to break up and the sun popped through now and then. It was too wet to go into the field. Josh told Ellen to cook him a big thick pone of cornbread mixed with some strands of cotton, and he would go over to White's Bluff and catch a few carp for supper.

"He rode his mule but did not take his pole because one of the chillun had run over it with a loaded wagon."

Right at daylight Saturday morning, Will said, he heard somebody in the front yard hollering, "Mr. Lowery! Mr. Lowery! Mr. Lowery!" He opened the front door. It was Ellen and she said that Josh hadn't come home all night, explaining that he had gone fishing. With a tearful and plaintive voice she said, "Josh ain't never failed to come home in all his life either jest before or jest after sundown."

Will said that he woke up his wife and his oldest boy. After a hurried breakfast, he cranked up his model T and they drove to White's Bluff on the river. There was

Josh's mule still tied. They went to the bluff, which was about 10 feet above the river. There was a deep hole at the foot of the bank that had been washed out as the river took a long bending curve. They found Josh's cap about half way down and marks on the wet ground as though he had slid into the river. There were a good many heel prints as though he had tried to check his slide.

The alarm spread and by Saturday afternoon several boats paddled up and down the river below where he had gone in.

On Sunday morning a boat spotted something suspicious in some willow bushes. It was Josh. He was bobbing up and down as the current played tricks. They had a hard time untangling him from the willows and getting him into the boat. Finally one person discovered the cause . . . a stout fishing line was tied around his big toe on his left foot and was tangled in the underwater branches of the willows. They cut the line and got him into the boat, but Will said that he held on to the other end and finally untangled it. He did this because he kept thinking that he could feel a tug on it now and then. When the line was freed, he pulled up this tremendous carp, the biggest that he had ever seen. The fish was almost spent. He had fought and fought and had almost torn the hook from his right eye down to his lip. Will said that he pulled him gently toward him, got his hand under his belly, but just as he touched him the fish gave a last convulsive giant twist and the hook tore from his lip. He lay on his side a few seconds, just out of reach, completely spent, then the current caught him. As soon as he realized that he was free, he righted himself and disappeared.

"And so, the way we figured it, Josh must have baited his hook, and since he did not have a pole, he eased down the wet slippery bank to the water's edge, threw out the bait, then climbed around back up to the dry top where he leaned back on a big tree, let his feet hang over the bank, and held the line in his hand. After a while, he got sleepy, took off his shoe, tied the line around his big toe and lay down on the soft warm grass at the top of the bluff and went to sleep. There must have been some slack in the line and this big ole carp swallowed the bait, hook and all and fooled around a little until he felt something stick him down in the gullet. Then he took off in a hurry to deep water and before Josh knew what was happening, he was sliding down the slick bank and out into the water.

"That's the same fish there, boys, because I looked at him good as I was bringing him toward the boat and when I put my hand under his belly. And that scar running from his eye through his lip is where the hook tore loose.

"He's the one that drowned my friend, Joshua Jones."

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SOCIETIES

The January 6 meeting of the **Bibb County Medical Society** included a discussion of "Religious Aspects of Death—What Is Death?" led by Father John Cuddy of St. Joseph's Catholic Church and the Rev. Reece Turrentine of Riverside United Methodist Church.

The 1976 officers of the Cherokee-Pickens Medical Society are: G. William Glazebrook, Canton, president; Keith Parmer, Canton, vice president; and F. E. Gonzalez, M.D., Canton, secretary-treasurer.

The First Annual President's Roast, honoring outgoing president Lawrence L. Freeman, was held by the **DeKalb County Medical Society** in mid December. Roasters were John Heard, Charles McDowell, L. C. Buchanan, LaMar McGinnis and Jay Coffsky. The new slate of officers for DeKalb County includes Dr. McGinnis as president; Stanley P. Aldridge, president-elect; Duane Blair, vice-president and Dr. McDowell, secretary-treasurer (second year of two year term). MAG delegates are Roy W. Vandiver, Drs. McDowell, McGinnis and Blair.

L. Newton Turk, Atlanta thoracic surgeon has taken over as 1976 president of the **Medical Association of Atlanta.** Other new officers are president-elect William E. Huger, councilor to MAG Harold Harrison and trustee-at-large Charles E. Harrison, Jr. The elections came during the society's annual meeting in December at which others were honored for 50 and 25 years of membership in the society, and life memberships were presented to four physicians.

New officers have been installed for the **Richmond County Medical Society.** Thomas G. Douglass will serve as president, Joseph P. Bailey, president elect, Jimpsey B. Johnson as vice president and Charles H. Waray as secretary-treasurer.

PERSONALS

First District

Frank T. Robbins of Hinesville has been accepted into the Southeastern Surgical Conference and has been elected to serve a three year term as director of the National Association of Nursing Home Physicians.

A portrait of **James Clayton Metts** of Savannah has been presented to the Memorial Medical Center of Savannah, honoring the physician who was instrumental in establishing and planning the hospital. Dr. Metts served as its chief of staff during Memorial's early years.

Second District

Thomasville pediatrician **Randy Malone** has compiled and published a 166-page spiritual songbook

titled "Scripture Sings," published by New Life Publications in his hometown.

Fourth District

A branch office for The Children's Medical Group, headquartered in Century Center Office Park, has been opened for morning hours off I-20 between Conyers and Covington. The firm consists of Drs. **H. Luten Teate, Forest D. Jones, Thomas M. Browne** and **David L. Morgan.**

Fifth District

W. Dean Warren of Atlanta was presented the Seale Harris Award at the 69th annual session of the Southern Medical Association in Miami Beach recently.

Bernard Lipman has been promoted at Emory University School of Medicine from clinical associate professor of medicine to clinical professor of medicine.

Ninth District

George T. Nicholson of Cornelia has moved his offices from 469 North Clarkesville Street to the U. S. 441 North Shopping Center. He also has been notified that he will receive a Fellowship into the American Academy of Family Physicians at its convocation in Boston next September.

Tenth District

The Madison office of **Francisco Pagsisihan** has been closed as the doctor has joined the U. S. Air Force and will be stationed at Clark Air Force Base in his native Philippines.

Paul D. Webster, III, Augusta, served as a course director during the Southern Medical Association's program in Miami Beach recently.

Robert B. Greenblatt, professor emeritus for the Medical College of Georgia has been elected president of the International Family Planning Research Association, Inc. out of Palm Springs, Calif. He also is the first American named honorary member of the Mexican Endocrine Society.

Paul G. McDonough, Augusta, has been awarded special certification by the American Board of Obstetrics and Gynecology in the Division of Reproductive Endocrinology.

DEATHS

Frank H. Sams, Sr.

Reynolds physician Frank H. Sams, Sr., who practiced for over 40 years, died December 16 at the age of 67. He was graduated from the University of Georgia and the Medical College of Georgia and served his internship and residency at what is now the Medical Center of Central Georgia. Dr. Sams built Sams Hospital after moving to Reynolds from Macon.

He was a member of the Association of Surgeons of the Southern Railway System and served during World War II in the U. S. Army Medical Corps. He was awarded the Bronze Star, Purple Heart and three Battle Stars for his efforts.

Dr. Sams was a charter member of the Reynolds Kiwanis Club and was a Mason and Shriner. He was active in the Reynolds United Methodist Church.

Survivors include his widow, Mrs. Lois Newson Sams; three sons, Dr. Frank H. Sams, Jr. of Reynolds, H. Clinton Sams and Henry L. Sams of St. Augustine, Fla.; and a brother, Arthur Sams of Dalton.

Hiram Frazer Sharpley

Savannah obstetrician and gynecologist Hiram Frazer Sharpley, 74, died November 30 following a long illness. Dr. Sharpley had retired in June after 50 years of medical practice during which he delivered an estimated 10,000 infants.

The Savannah native served as chief of the medical staff at Telfair Hospital for five years, and was past president of the Chatham-Savannah Health Council. Maternal deaths were a special concern of his and he served as chairman of the MAG Maternal and Infant Welfare Committee for 17 years. Dr. Sharpley was a Diplomate of the American Board of Obstetrics and Gynecology, a member of the Rotary Club, Savannah Yacht Club and St. Andrew's Independent Episcopal Church. He was a charter member of the South Atlantic Association of Obstetricians and Gynecologists and belonged to the state and national Ob-Gyn societies.

Survivors include his widow, Edna Hunsberger Sharpley; daughter, Mrs. Ridar A. Trosdal of Savannah; sons, Don Frazer Sharpley of Savannah and Thomas Loxley Sharpley of Norfolk, Va.; sister, Mrs. Marion L. Cowart of Savannah; brother, Dr. John Gartner Sharpley of Savannah; nine grandchildren.

Fred Huie Simonton

Fred Huie Simonton, 70, past president of the Medical Association of Georgia (1961-1962) and the Georgia Academy of Family Physicians, died December 7 in a hospital near his Chickamauga home.

MAG named Dr. Simonton "General Practitioner of the Year" in 1958 and he received the Outstanding Alumnus Award of West Georgia College in Carrollton in 1974. He served as president of the Walker-Catoosa-Dade and Seventh District medical societies, was a charter member and past vice president of the American

GAFP SELECTS NEW OFFICERS

New officers of the Georgia Academy of Family Physicians were selected at the organization's annual meeting November 21, 1975 at the Executive Park Motor Hotel in Atlanta. Wells Riley is the new president, assisted by Milton Johnson of Macon as vice president and H. Gordon Davis of Sylvester as president-elect.

The Distinguished Service Award went to Jon Calvert, Augusta, for writing and producing the family medicine refresher course.

Several new district directors and alternates were also chosen: for the Second District, Charles Lamb of Albany is the director; Howard Vigrass of Columbus is the director for the Third District and Perry Busbee of Cordele is the alternate; Fourth District director is Lawrence Freeman of Decatur; for the Ninth District William Ford of Lavonia is the new alternate; and in the Tenth District George Green of Sparta will serve as director and Joseph Tollison of Athens is the alternate. Jack Root of Columbus was chosen as a director representing residents.

Academy of Family Physicians. Dr. Simonton served 17 years on the Georgia State Board of Health, including four years as chairman of the board.

He was graduated in 1929 from the Medical College of Georgia and served his internship and residency as the first U. S. District Public Health Officer of Walker, Dade, Chattooga and Catoosa counties. His private practice was opened in 1933 in Chickamauga and he operated the Simonton Clinic until 1953. For several years he served as chief of staff for Hutcheson Memorial Hospital and its Houston Jewell Medical Care Unit.

Dr. Simonton was appointed by Pres. Eisenhower as general practice consultant to the U. S. Health, Education and Welfare Commission on Chronic Diseases and Rehabilitation and was special consultant to the White House Conference on Aging in 1958. In 1961 he toured 10 European countries studying methods of care for the aging and mental patients for the Georgia Dept. of Public Health Program for Mental Health and Retardation.

Survivors include his widow, Mrs. Louise McDonald Simonton; daughter, Mrs. Sylvia Malone Simonton Bohanan of Carrollton; son, Fred Simonton, Jr. of Marietta; three grandchildren; two brothers, Carl Simonton of Carrollton and Merlin Simonton of Macon.

Eugene Spier

Atlanta physician Eugene Spier, 53, died December 4. He was the senior anesthesiologist at Piedmont Hospital since 1951 and was a member of the Georgia, Southern and American anesthesiology associations.

Dr. Spier attended Emory University where he was a member of Sigma Alpha Epsilon social and Phi Chi medical fraternities. He was a past president of the Buckhead Exchange Club and a member of the Cherokee Town and Country Club where he was active in tennis competitions. He was a member of Trinity Presbyterian Church.

Dr. Spier is survived by his widow, Mrs. Martha Mitchell Spier; daughters, Mrs. Roger Weaver and Miss Nancy Spier of Atlanta; son, George Eugene Spier of Atlanta; sister, Anne Spier of LaGrange and brother, Wallace B. Spier of Ft. Walton Beach, Fla.

Robert L. Whipple, Jr.

Emory alumnus Robert L. Whipple, Jr., 60, of Atlanta died November 23. Dr. Whipple was a member of the Georgia Society of Internal Medicine, American Federation of Clinic Research, national associations for heart, diabetes and arthritis, American Board of Internal Medicine and was a fellow in the American College of Physicians. He was an assistant clinical professor of internal medicine at Emory.

Survivors include his widow, the former Aileen Shortley; daughter, Mrs. Susan Sikes of Atlanta; sons, Robert L. Whipple, III, M.D., A. Harvard Whipple, and Joseph E. Whipple, all of Atlanta, Stephen B. Whipple, M.D. of Charleston, S. C.

The Month in Washington

The continual improvement in our health system, with its ever-increasing responsiveness to the people's needs, must not be stifled by adopting foreign-flavored elements into a national health insurance plan, the American Medical Association has told the Congress.

"When considering a national plan for this country, it is necessary to take cognizance of the strengths of our own method of health care delivery . . . this will assure that our excellent system will continue to improve and will not suffer the stifling effects experienced in other countries," AMA president Max H. Parrott, M.D. testified before a subcommittee of the House Ways and Means Committee.

Pointing to the large problems involved in creating a national health insurance program, Dr. Parrott, a Portland, Ore., practitioner, said that the public attitudes toward it are changing steadily.

"These problems have been brought into better focus as a result of evidence of the effects of governmentally administered and controlled programs both here and abroad.

"Our national priorities have also shifted because of the effects of the changing economy, and the devastating effects of inflation on all segments of our society.

"The public has expressed among its major priorities a concern with inflation, with the state of the economy, and with crime. National polls have indicated that national health insurance is of low concern.

"During this same period of time significant changes have taken place in our health system through increased manpower programs, increased facilities construction, increased levels of private health insurance coverage, and a variety of other programs. There is fuller realization and acknowledgment that this country's health system—under attack by many in the course of the NHI debate—is indeed superior to any other in the world," Dr. Parrott said.

Dr. Parrott and Richard E. Palmer, M.D., of Alexandria, VA, and Chairman of the AMA Board of Trustees, reminded the subcommittee members of the medical profession's national health insurance plan (H.R. 6222) which builds on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 per cent of the cost.

Dr. Palmer pointed out that in pressing for the adoption of any particular NHI proposal, sincerity must not be confused with objectivity—"We cannot afford to have a program of such importance fail!

"We must avoid the mistake inherent in proposals such as H.R. 21 (Kennedy-Corman) which would lock medicine into a rigid, monolithic, no-choice bureaucratic system. Such a creation would be impossible to reverse. It would be an undertaking full of promise but empty of fulfillment. Establishment of cost control through fixed budgets including arbitrary fee schedules would result in curtailment of care and discourage participation by providers. A look at the current trouble of the British health care system impels a close re-examination of the alleged need for such drastic action, as is embodied in H.R. 21. In our opinion justification for such a program is totally lacking!"

Alluding to other measures aimed at providing catastrophic health insurance alone, Dr. Palmer observed that 135 million Americans under 65 carried major medical insurance in 1974.

"This is the most rapidly growing form of health in-

surance in the nation, and the trend for such added coverage is fostered by an increasing public awareness. Consequently, we must question the need to impose on the American taxpayer and consumer a costly universal federal program of free-standing catastrophic insurance."

NHI Battle in Congress

The National Health Insurance hearings on Capitol Hill have been marked so far by a notable lack of excitement or sense of urgency. The national news media has ignored the first legislative hearings of the year on NHI, underscoring contentions by many witnesses that the public doesn't rate NHI high on its scale of worries or interests.

Nonetheless, the recently announced decision that the House Interstate and Foreign Commerce Committee's Subcommittee on Health will conduct NHI hearings, brings into the open anew the odd jurisdictional dilemma that preplexes Congress in its quest for action on NHI. Rep. Paul Rogers (D-Fla.) has announced his House Commerce Subcommittee on Health will start NHI hearings. He plans to call first the chief Congressional sponsors of the major NHI bills to testify. Rogers is telling the House Ways and Means Committee in unmistakable terms that he wants a piece of the NHI action, perhaps the big piece.

The Ways and Means Subcommittee on Health, headed by Rep. Dan Rostenkowski (D-Ill.), will end six weeks of hearing on NHI just as Rogers gets started. Relations between the rival panels and their staff members are strained.

Since Ways and Means traditionally has had prime jurisdiction, the chief sponsors of the NHI bills in the House are for the most part members of the Ways and Means Committee. Examples include Ways and Means Chairman Al Ullman (D-Ore.), sponsor of the American Hospital Association's plan, Rep. John Duncan (R-Tenn.), a chief sponsor of the American Medical Association's NHI proposal, Rep. Omar Burleson (D-Texas), foremost House backer of the Health Insurance Companies' measure, and Rep. James Corman (D-Calif.), sponsor of Labor's Health Security Act.

None are anxious to go before the Rogers' Subcommittee in behalf of their bills, thus lending support to Rogers' jurisdictional claim.

The way health jurisdiction has been parcelled out in the House this year, Rogers can lay valid claim to much of the benefit and structural side of NHI legislation while Ways and Means has acknowledged hold on all tax financing aspects. But the question remains: Can these be separated? Most believe they can't and some special joint-committee setup will have to be formed to avoid a divisive squabble in the House pitting one major committee against another.

Skyrocketing Premiums

A Congressional committee trying to ascertain the causes of a large hike in premium costs for the huge Federal Employees Health Benefits Program (FEHB) has been told by the American Medical Association that physicians' long-run prices have paralleled price changes elsewhere in the economy.

William C. Felch, M.D., of Rye, N.Y., a member of the AMA Council on Legislation, told the House Civil Service Subcommittee that professional liability expense "has increased far beyond any other economic indicator."

Dr. Felch said "this skyrocketing of professional liability premiums is of necessity reflected by higher fees." He continued:

"The most recent premium increases are staggering. Increases of 100 per cent are frequent, with increases ranging up to 600 per cent."

Premiums of $10,000 are not unusual today, Dr. Felch told the lawmakers. "Amounts in the range of $25,000 to $30,000 in the high risk specialties are not rare, as compared with $6,000-$7,000 a year ago. Some premiums have been reported as high as $45,000 annually."

The other major factors in medical fee rises are the lingering effects of the economic stablization program and economy-wide inflation, the physician said. Physicians' fees were under price controls from August 1971 through April 1974, he noted.

Consumer price figures for 1975 show that the percentage increase in physicians' fees has been lower than the price increases in the hospital industry but higher than the price increases in the economy in general, according to Dr. Felch.

"During the first nine months in 1975, physicians' fees increased 8.4 per cent. In the same time period other health care costs were as follows: hospital service charges up 10.2 per cent, semi-private room charges up 12.0 per cent and operating room charges up 10.4 per cent."

Dr. Felch also said utilization of physician services has risen with progress of medical technology, rising incomes, increased insurance coverage, and a rising proportion of elderly in the population. "These factors no doubt have combined to increase the costs in the Federal Employees' Benefit Program. We understand that the FEHB as well as other plans have experienced sharp rises in utilization."

Another reason for increased utilization may be more extensive tests and services as a result of threats of liability lawsuits, he said.

Dr. Felch said the AMA has recently approved the creation of a high level commission to study the problem of rising health care costs. This Commission on the Cost of Medical Care will include top level representatives of health care providers and of the public, reflecting a broad spectrum of interest in health care. "It is our desire that through the joint efforts of all members of the Commission, the causes for health care cost increases will be better understood."

Required HMO Membership

The Administration has had a change of mind and now backs legislation that would bar unions from requiring members to join federally-subsidized Health Maintenance Organizations (HMOs).

Referring to a provision in the HMO bill recently passed by the House, Theodore Cooper, M.D., Assistant HEW Secretary for Health, said "this amendment would assure that each individual employee would have the right to choose to participate before joining."

Dr. Cooper's statement before the Senate Health Subcommittee represented a switch in Administration policy. Only a month ago, the HEW Department issued regulations on HMOs that allowed unions at the collective bargaining table to choose an HMO or regular

private health insurance on behalf of the entire union membership.

The original HMO measure approved by Congress specified that all employers with more than 25 workers had to offer the "dual option" of HMO or regular insurance to their employees in areas where HMOs were situated and sought this option. However, this clause caused confusion and was viewed by labor—backed by the Labor Department—as interfering with Labor's present collective bargaining rights to pick a single health benefit package. In issuing final regulations on HMOs last month, HEW went along with Labor's viewpoint.

As the Senate Health Subcommittee headed by Sen. Edward Kennedy (D-Mass.) opened hearings on the House-passed amendments to the HMO law, Dr. Cooper said "we endorse the clarification of existing law which provides that an employer offer an HMO option under 'dual choice' first to the employees' representative, if any, and, if accepted by the representative, then to the individual employees."

The House measure retained Labor's collective bargaining opportunity to select a regular private health insurance program as the sole health benefits program, but said that employees could not be forced to accept an HMO.

The problem with the Labor Relations Act and the "dual option" may eventually have to be settled by the courts. A key issue is whether union membership can be required in total to join a plan that is federally subsidized. A non-subsidized HMO or pre-paid group practice plan may, of course, be selected by Labor for all members without question.

Health Manpower Legislation

Federal controls dictating where medical graduates practice, rationing of residencies, and federal licensure and re-licensure of physicians have been strongly opposed by the American Medical Association.

Further governmental regulations may "have adverse effects on the forces which are bringing about desired changes without regulatory intervention," said Tom Nesbitt, M.D., speaker of the AMA's House of Delegates.

Dr. Nesbitt told the Senate Health Subcommittee headed by Sen. Edward Kennedy (D-Mass.) that the AMA supports continued capitation and other aid for medical schools, but provisions requiring students to repay the government in money or in shortage area service in return for the capitation aid are "coercive and unprecedented."

"Such requirements would place an unconscionable burden on students," Dr. Nesbitt declared.

The Senate Subcommittee is finishing hearings on health manpower legislation and is expected to draft legislation shortly. The House last fall approved a health manpower bill extending federal aid for medical schools but imposing the compulsory payback on the students. A provision mandating allocation of residencies, however, was defeated on the House floor.

From the standpoint of the medical school finances, the battle over whether federal capitation support will continue has already been won, with the pro-support HEW Department finally getting the upper hand in an intra-administration dispute with the Office of Management and Budget which wanted to end federal subsidies for medical schools.

Dr. Nesbitt told Kennedy's Subcommittee that federal scholarships should continue, not only those tied to service in the Public Health Service and National Health Service Corps, but scholarships with no strings attached for students in severe financial need from the socioeconomic disadvantaged. Funds for student loans also are needed, he said.

Proposals to regulate the total number of first year residency provisions, their geographic location, and their distribution by specialty were labelled "unnecessary and unwise" by the AMA official.

The number of residency positions is declining at the same time the number of medical school graduates is increasing, Dr. Nesbitt noted. "It is a particularly inappropriate time to establish arbitrary legislative ceilings on total residency positions."

The goal of such allocations is to increase the number of "primary care" physicians. However, Dr. Nesbitt pointed out that last year 58 per cent of graduate students entered "primary care" specialties, more than the 50 per cent goal set by the AMA previously. What Congress is seeking is already being accomplished, without legislation, he said.

Medicare Reimbursements

The House Ways and Means Committee has approved four technical amendments to the Medicare law including one which would forestall rollbacks in some physicians' Medicare reimbursement.

An unintended effect of the HEW Department's new Medicare reimbursement index tying physicians' Medicare fees to a cost-of-living-type formula was to cause some reimbursement levels to be less this year than last despite rises in the cost of living. The Ways and Means amendment would prevent any reimbursement to be less this fiscal year than allowed previously.

The AMA had urged this change. The other amendments dealt with reimbursement for teaching hospitals, the Federal Employees Health Benefits Program, and extension of an exemption for certain nurse staffing requirements in rural hospitals.

Privacy vs. Right to Know

Two broad philosophical principles—the right of privacy and the public's right to know—are colliding in Federal health programs. The dilemma was pointed up recently when the Federal Medicaid program decided the Freedom of Information Act required it to release upon request the names of physicians who collected more than $100,000 yearly from Medicaid payments.

The HEW Department said 207 physicians last year received more than $100,000 from Medicaid. The names of 13 New Jersey physicians were released immediately and all other names will be made public, HEW officials said. The names were requested by the *New York Daily News* and other newspapers on the basis of the Freedom of Information Statute designed to open up the workings of the Federal Government to public scrutiny.

Medicaid officials made clear that the figures were gross receipts and that there was no suggestion of any abuse or impropriety. Dr. Keith Weikel, Federal Medicaid Director, told a small group of newsmen that he was concerned that disclosure of the physicians' names might discourage some physicians from treating Medicaid patients, but he added that the Agency felt the information law required release. ■

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost. Copy and payment should be received by the 20th of the month preceding publication. Mail to the *Journal of the Medical Association of Georgia*, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

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Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

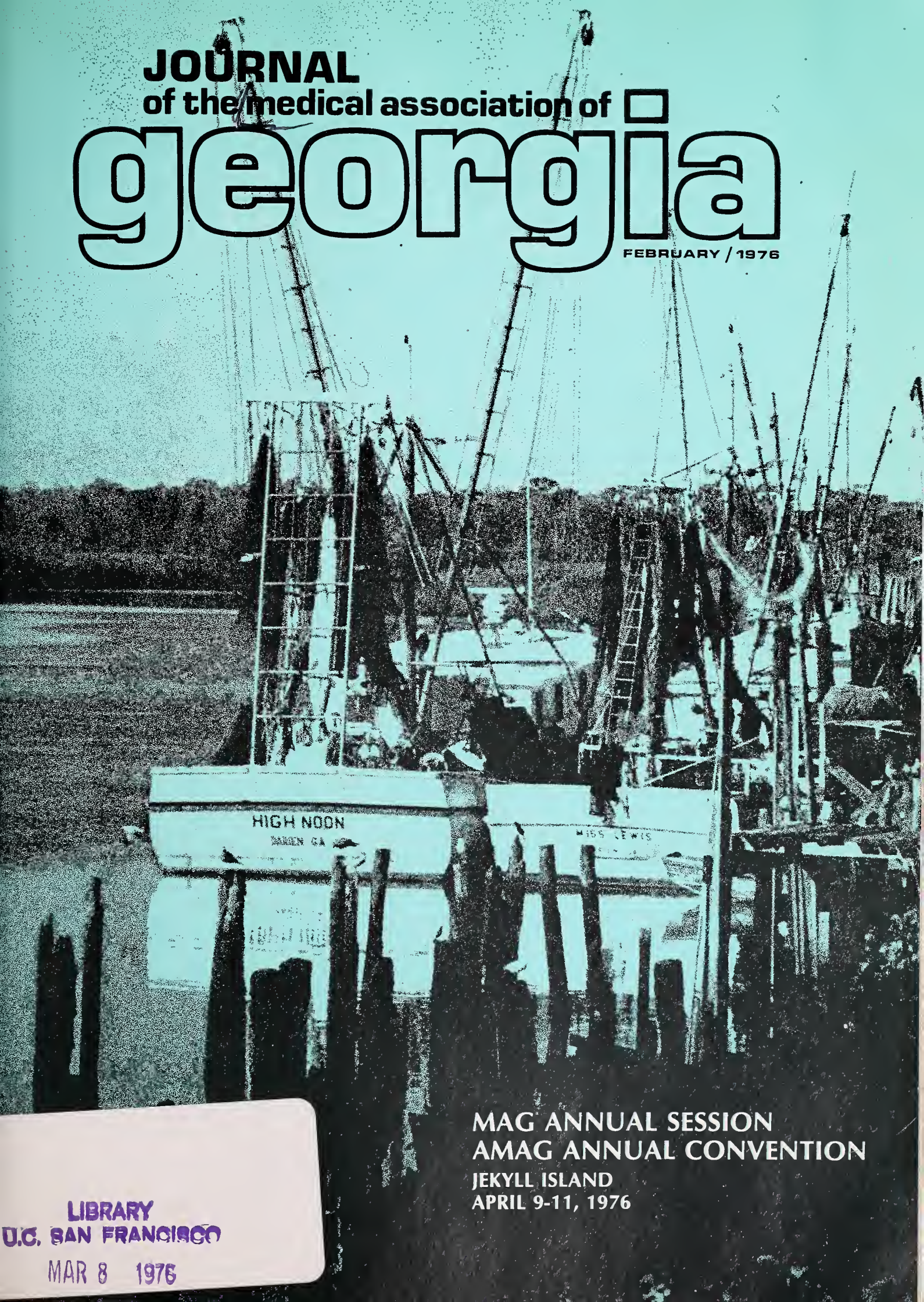
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque and/or severity of grand mal seizures r require increased dosage of standard a convulsant medication; abrupt withdra may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous i gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) ha occurred following abrupt discontinuar (convulsions, tremor, abdominal and m cle cramps, vomiting and sweating). Ke addiction-prone individuals under caref

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Graceful shrimp boats dot the coastline of Georgia's Golden Isles, location of the 1976 MAG Annual Session. Layout by Bob Hamill. Photograph courtesy of the Georgia Department of Natural Resources.

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Official Call

To the officers, delegates, and members of the Medical Association of Georgia to attend the 122nd Annual Session of the House of Delegates

On Jekyll Island

April 9, 10 and 11, 1976

THE HOUSE OF DELEGATES will convene at 10:15 a.m. on Friday, April 9, in the Colony Hall of the Holiday Inn. The House of Delegates will be preceded by a General Session of Association members at 9:00 a.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the Scientific portion of the meeting was separated from the business portion and is being held in November of each year.

Hotel Reservations

Officers, councilors and delegates will have first priority for rooms at the Holiday Inn. Members of the Auxiliary to MAG will be headquartered at the Atlantic Carriage Inn. MAG also has room blocks at the Sand Dollar, Sheraton-by-the-Sea, and the Buccaneer Inn. Please use an official housing form in this issue of the *Journal* or write directly to the hotel of your choice.

Registration

Registration facilities will be maintained in the main lobby of the Holiday Inn just outside Colony Hall, for delegates, alternate delegates, councilors, vice councilors and others. Registration hours will be as follows:

Thursday, April 8	4 p.m.-7 p.m.
Friday, April 9	7:30 a.m.-5 p.m.
Saturday, April 10	8:30 a.m.-12 Noon
	(After 12 noon, please come to MAG Headquarters office.)
Sunday, April 11	7 a.m.-12 Noon

Headquarters Office

The Association staff will maintain an office just off the lobby of the Holiday Inn.

Message Center

The Auxiliary to the MAG will maintain a message desk in the lobby of the Holiday Inn for the convenience of the membership. Names displayed on a projection screen in the House of Delegates will alert the members of an incoming message. The messages will be posted on a bulletin board at the message desk.

General Sessions

The opening session will be called to order by the President, David A. Wells, M.D., on Friday, April 9, at 9:00 a.m., in Colony Hall of the Holiday Inn. Featured during this opening ceremony will be the presentation of the Association awards, report of the President of the Auxiliary to MAG, and an address by Max H. Parrott, M.D., of Portland, Oregon, President of the American Medical Association.

There will be no General Session on Saturday in 1976.

The Second General Session will be held following the adjournment of the House of Delegates on Sunday, April 11. At this time the newly elected officers will be installed and the new President of the Association will address the membership.

House of Delegates

The first session of the House of Delegates will convene on Friday, April 9, at 10:15 a.m. in Colony Hall of the Holiday Inn. At this time nominations for MAG officers will be made. Reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference Committees will be appointed and all resolutions and reports will be referred by the Speaker to the appropriate Reference Committees.

The second session of the House will convene at 9:00 a.m. on Sunday, April 11, in Colony Hall. Reference Committees will report to the House at this time.

Reference Committees

According to the Bylaws of the Association, all reports which contain recommendations and resolutions must be referred to Reference Committees

for open hearings. All members are invited and encouraged to appear before the Reference Committees to express their views. The Reference Committees will open their hearings on Friday, April 9, one and a half hours following the recess of the House of Delegates, or approximately 1:30 p.m.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Friday, April 9. The election will take place before the House of Delegates Sunday, April 11. Delegates may vote by secret ballot any time between 7:00 a.m. and 9:00 a.m., when the polls will close. Delegates will be certified by members of the Credentials Committee and receive their ballots at that time. There will be appropriate voting booths and a secure ballot box. After the polls close at 9:00 a.m., the Tellers Committee will count the ballots and the results will be announced at the General Session following the adjournment of the House of Delegates. If it is necessary to have a run-off election it will be held during the House meeting.

GaMPAC Brunch

This annual highlight of the Annual Session will be held on Saturday, April 10, in the Colony Hall of the Holiday Inn. A nationally recognized speaker will be featured at this event. All MAG and Auxiliary members are invited to attend.

President's Reception

The Association will honor its President at a reception to be held at 6:30 p.m., Saturday, April 10 in Colony Hall at the Holiday Inn. All members and their guests are invited to attend.

Alumni Events

Reception and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

AMA PRESIDENT MAX H. PARROTT

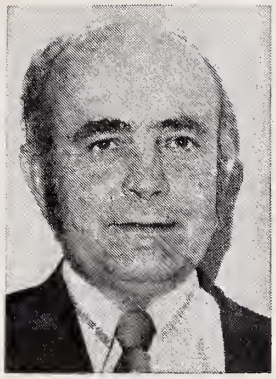


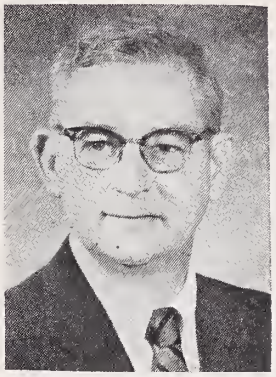
Guest speaker at Friday's opening General Session is Max H. Parrott, M.D., a Portland, Oregon obstetrician-gynecologist who is the AMA's 113th president.

Dr. Parrott had served the AMA as a member of the Board of Directors since 1966 and as chairman of the Board from 1970-1972. He represented his state in the House of Delegates from 1961-1966 and served on the Council on Legislation from 1961-1965. He is a past president of the Oregon Medical Association and helped establish that state's Political Action Committee, serving as its first chairman in the early 1960's.

The Saskatchewan, Canada native earned his M.D. degree from the University of Oregon Medical School, and, following his internship, served in the U. S. Army Medical Corps during World War II. He is a diplomate of the American Board of Obstetrics and Gynecology and a member of the American College of Ob-Gyn. For the University of Oregon Medical School he is an assistant clinical professor.

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1975-1976


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HAVERTY


JORDAN


SULLIVAN


ATKINS


BURGSTINER


BUCHANAN


GALLOWAY


ELDRIDGE

OFFICERS

Position		*Term Ending*
President	David A. Wells, Dalton	1976
President-Elect	Fleming L. Jolley, Atlanta	1976
Immediate Past President	J. Rhodes Haverty, Atlanta	1976
Past President	C. Emory Bohler, Brooklet	1977
Past President	F. William Dowda, Atlanta	1976
First Vice President	W. Dan Jordan, Atlanta	1976
Second Vice President	James H. Sullivan, Columbus	1976
Chairman of Council	Fleming L. Jolley, Atlanta	1976
Secretary	Earnest C. Atkins, Atlanta	1978
Treasurer	Carson B. Burgstiner, Savannah	1978
Speaker of the House	L. C. Buchanan, Decatur	1977
Vice Speaker of the House	Ronald F. Galloway, Augusta	1977
Chairman of the Finance Committee	F. G. Eldridge, Valdosta	1976
Editor *JMAG*	Edgar Woody, Jr., Atlanta	1976

COUNCILORS AND VICE COUNCILORS

District	*Councilor*	*Vice Councilor*	*Term Ending*
1	Albert M. Deal, Statesboro	Leon E. Curry, Metter	1976
2	J. Dan Bateman, Albany	Frank R. Miller, Thomasville	1976
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1976
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1977
7	Don Schmidt, Cedartown	Richard A. Griffin, Cartersville	1977
8	Robert E. Perry, Jr., Brunswick	Joe C. Stubbs, Valdosta	1977
9	Harvey M. Newman, Gainesville	L. Austin Flint, Canton	1978
10	Edwin W. Allen, Jr., Milledgeville	M. A. Hubert, Athens	1978
Bibb County Medical Society			
	Milton I. Johnson, Macon	Beverly B. Sanders, Macon	1978
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1978
DeKalb County Medical Society			
	Luther M. Vinton, Avondale Estates	Stanley P. Aldridge, Decatur	1978
Medical Association of Atlanta			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1977
	T. J. Anderson, Jr., Atlanta	William D. Logan, Atlanta	1976
	J. Harold Harrison, Atlanta	W. W. Moore, Jr., Atlanta	1976
Georgia Medical Society			
	L. R. Lanier, Jr., Savannah	Irving Victor, Savannah	1976
Muscogee County Medical Society			
	Jack A. Raines, Columbus	Louis A. Hazouri, Columbus	1977
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Henry D. Scoggins, Augusta	1978

AMA DELEGATES AND ALTERNATE DELEGATES

Delegate	*Term Ending*	*Alternate Delegate*	*Term Ending*
C. E. Bohler, Brooklet	12-31-77	F. G. Eldridge, Valdosta	12-31-77
F. W. Dowda, Atlanta	12-31-77	Charles D. Hollis, Albany	12-31-77
Harrison L. Rogers, Atlanta	12-31-76	H. Hilt Hammett, Jr., LaGrange	12-31-76
J. Dan Bateman, Albany	12-31-76	W. W. Moore, Atlanta	12-31-76

Component County Society Representation to the 1976 House of Delegates

County Society	*Number of Delegates*	*County Society*	*Number of Delegates*
Altamaha	1	Cobb	9
Baldwin	3	Coffee	1
Barrow	1	Colquitt	1
Bartow	1	Coweta	1
Ben Hill-Irwin	1	Decatur-Seminole	1
Bibb	9	DeKalb	10
Blue Ridge	1	Dougherty	4
Ogeechee River	2	Camden-Charlton	1
Burke	1	Emanuel	1
Carroll-Douglas-Haralson	2	Flint	1
Georgia Medical Society	9	Floyd-Polk-Chattooga	4
Elbert	1	Franklin-Hart	1
Chattahoochee	2	Medical Association of Atlanta	45
Cherokee-Pickens	1	Glynn	3
Crawford W. Long	3	Gordon	1
Clayton-Fayette	2	Habersham	1

County Society	Number of Delegates
Hall	4
Peach Belt	2
Jackson-Banks	1
Jefferson	1
Laurens	2
McDuffie	1
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	8
Newton-Rockdale	1
Oconee Valley	1
Ocmulgee	1
Randolph-Stewart-Terrell	1
Richmond	14
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	1
Sumter	1
St. John's Parish	1
Telfair	1
Thomas Area	3
Tift	1
Troup	2
Upson	1
Walker-Catoosa-Dade	2
Walton	1
Ware	2
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than March 1, 1976. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented on Friday, April 10. By custom this award usually has gone to a Georgia physician. However, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than March 1. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Friday, April 10.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters office no later than March 1. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Friday, April 10.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The name of the family physician, accompanied by supporting biographical data was to be received at MAG Headquarters by March 1. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Friday, April 10.

Official Program

(All functions of the House of Delegates will be held in the Holiday Inn)

THURSDAY, APRIL 8

4:00-7:00 p.m. — **General and Delegates Registration**
Lobby

FRIDAY, APRIL 9

7:30 a.m. — **General and Delegates Registration**
Lobby

9:00 a.m. — **General Session**
Colony Hall
Presiding: David A. Wells, M.D., President

Opening Ceremonies
Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Phil Astin, Carrollton

Greetings: Mrs. Norman H. Gardner, East Hampton, Conn., President-Elect, Auxiliary to the American Medical Association

Presentation of MAG Awards:
- AMA/ERF Checks
- Family Physician of the Year
- Hardman Cup
- Civic Endeavor Award
- Distinguished Service Awards

Address by Max H. Parrott, M.D., Portland, Ore., President of the American Medical Association

Announcements

Recess

10:15 a.m. — **House of Delegates**
Colony Hall
Presiding: L. C. Buchanan, M.D., Speaker, and Ronald F. Galloway, M.D., Vice Speaker

Presentation, Correction and Adoption of the Minutes of the 1975 House of Delegates

Appointment of Convention Committees

Nominations for Association Officers and AMA Delegates

Reports of Officers and Committees

Introduction of New Business

Announcements
Recess

1:30 p.m. — **Reference Committee Hearings**
Colony Hall

SATURDAY, APRIL 10

8:30 a.m.	**General and Delegates Registration** *Colony Hall*
	GaMPAC Brunch *Colony Hall* (All MAG members, Auxiliary members, and guests are invited to attend)
Afternoon	**Leisure**
6:30 p.m.	**President's Reception** *Colony Hall* (All MAG members, Auxiliary members, and guests are cordially invited)

SUNDAY, APRIL 11

7:00 a.m.	**General and Delegates Registration** *Lobby*
7:00-9:00 a.m.	**Polls Open for Election of Association Officers and AMA Delegates** *Lobby*
9:00 a.m.	**House of Delegates, Second Session** *Colony Hall* Presiding: L. C. Buchanan, M.D., Speaker, and Ronald F. Galloway, M.D., Vice Speaker
	Invocation
	Reports of Reference Committees
	Announcements
	Adjournment of House of Delegates
12:00 p.m.	**General Session, Final** *Colony Hall* Presiding: David A. Wells, M.D., President
	Announcement of Election Results
	Installation of Officers
	Address of the President, 1976-1977, Fleming L. Jolley, M.D., Atlanta
	Adjournment of 122nd Annual Session

Auxiliary 51st Annual Convention

April 8-10, 1976 · Atlantic Carriage Inn · Jekyll Island

President's Greeting



It is my pleasure to invite each Auxiliary and Executive Board member to the 51st Annual Convention of the Auxiliary to the Medical Association of Georgia, April 8 through April 10 at the Atlantic Carriage Inn at Jekyll Island.

The 1975-1976 term has been an interesting and fulfilling year for many Auxiliary members as well as state officers. Join us at the Annual Convention so that we may share ideas, projects and programs. This will be a good time to meet old friends and make new ones.

Looking forward to seeing you in Jekyll Island.

Mrs. Phil C. Astin, Jr.
President
Auxiliary to the Medical
Association of Georgia

Welcome to The Golden Isles



It is with pleasure that we, the members of the Glynn County Medical Auxiliary, welcome you to Brunswick and The Golden Isles for the 51st Annual Convention of the Auxiliary to the Medical Association of Georgia.

Much has been written about the area to which you are cordially invited this year and, no doubt, most of you are familiar with it. However, Mrs. Jack Smith, our very able and experienced convention chairman, with the full support of the Auxiliary members, indicates that new and interesting sights and thrills are in store for you. We hope that you will, also, enjoy the companionship and exchange of information with other auxiliaries.

We look forward to a full and happy participation in April!

Mrs. Frank B. Mitchell, Jr.
President
Glynn County Medical Auxiliary

Auxiliary Annual Convention Schedule

THURSDAY, APRIL 8

2:00-5:00 p.m.	Registration Lobby, Atlantic Carriage Inn
3:30-4:40 p.m.	Pre-Convention Executive Meeting Coach Room
4:30-5:30 p.m.	Orientation 1976-1977 Coach Room
6:30-7:30 p.m.	Reception Honoring Executive Board Surrey Room

FRIDAY, APRIL 9

9:00-10:00 a.m.	MAG General Session Colony Hall, Holiday Inn
	Report of Mrs. Phil Astin, President of the Auxiliary to the MAG
	Greetings: Mrs. Norman H. Gardner, East Hampton, Conn., President-Elect, AMA Auxiliary
	Address by Max H. Parrott, M.D., Portland, Ore., President of the American Medical Association
10:30-12:30 p.m.	First General Session Coach Room Guest Speaker: Mrs. Norman H. Gardner
	Memorial Service
1:00-2:30 p.m.	Luncheon Honoring State Committee Chairmen
3:30-4:30 p.m.	Tea Honoring National Guest, Mrs. Gardner

SATURDAY, APRIL 10

8:00-9:00 a.m.	Past Presidents' Breakfast
9:00-10:30 a.m.	Second General Session Coach Room Awards and Installation of Officers
11:00 a.m.	GaMPAC Brunch Colony Hall, Holiday Inn

HIGHLIGHTS OF EXECUTIVE COMMITTEE

January 9, 1976

Records Computerization: Recommended to Council computerization of MAG membership records at a cost of $500 per month.

Employee Retirement Fund: Received report on changes required based on federal law. Referred to staff for additional study and presentation in March.

Dues Increase: Discussed a possible dues increase to cover current deficit budgeting and for new member service programs.

Appointments/Nominations: Prison Health Care Committee—Walter E. Harrison, M.D., Moultrie. Committee on Laboratory Quality—Robert M. Trent, M.D., Decatur. Pharmacopeial Convention—Stanley P. Aldridge, M.D., Decatur. Health Manpower Linkage Project—J. Rhodes Haverty, M.D., Atlanta.

State Board of Medical Examiners—First District: Albert M. Deal, M.D., Statesboro; Carson B. Burgstiner, M.D., Savannah; Leon E. Curry, M.D., Metter; Thomas R. Freeman, M.D., Savannah; C. Emory Bohler, M.D., Brooklet. Sixth District: Wells Riley, M.D., Jonesboro; Thomas J. Hunt, M.D., Griffin; Talmadge M. Martin, M.D., Carrollton; J. Watts Lipscomb, M.D., Morrow; Ferrol A. Sams, Jr., M.D., Fayetteville. Ninth District: Robert E. Thompson, M.D., Toccoa; Paul L. Bradley, M.D., Dalton; Warren Dickey Stribling, M.D., Gainesville; L. Austin Flint, M.D., Canton; and Louis G. Cacchioli, M.D., Hartwell.

Fifth Pathway: Heard a report on licensure of foreign medical graduates through completion of clinical training without medical school graduation.

JCAH Standards for Medical Staff: Approved and referred to the American Medical Association changes suggested by the Medical Practice Committee.

Allied Health Licensure: Agreed to oppose any legislation to license additional allied health personnel.

Physician Answering Service: Referred to the Legislative Committee development of satisfactory mechanism to protect physicians and their patients in cases of answering services sudden cessation of business.

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION

April 9, 10, 11, 1976 ★ Jekyll Island, Georgia

HOTEL RESERVATION INFORMATION

1. The Holiday Inn has been designated as the Headquarters Hotel. Association officers, councilors and delegates will receive special housing forms for making their reservations at the Holiday Inn.
2. The Atlantic Carriage Inn is the Headquarters for the Auxiliary to MAG.
3. Assignment of rooms will be made in the order of receipt by the hotel of choice. Please indicate a second choice so that the hotel of first choice can forward the reservation, should they be completely booked.
4. *Make your reservations early.* Unreserved room blocks will be released on March 19.
5. Please use the form below and mail directly to the hotel of your choice.

HOTEL DAILY ROOM RATES
(European Plan—Meals Not Included)

ATLANTIC CARRIAGE INN: Beachview Drive, S., Jekyll Island, Ga. 31520
$22 Courtside Bedroom; $24 Poolside Bedroom; $28 Poolside Kitchenette
All rooms have two double beds. All rates are for one or two persons; each additional person $3 per day (seven years and older), $1 per day (under seven years).

BUCCANEER MOTOR LODGE: 85 Beachview Drive, S., Jekyll Island, Ga. 31520
$24 Courtside Bedroom; $27 Oceanfront Bedroom; $30 Courtside Kitchenette; $33 Oceanfront Kitchenette
All rates for one or two persons. Extra persons $2 per day. Children under 16 free. Roll-aways and cribs $3 per day.

SHERATON-BY-THE-SEA: P.O. Box 3040, Jekyll Island, Ga. 31520
$24 One Bedroom Townhouse (two persons); $30 Two Bedroom Townhouse (four persons); $36 Three Bedroom Townhouse (six persons)
Roll-away beds $3 per day; cribs $2 per day.
Each townhouse consists of bedroom(s), living room, dining room and kitchen.

SAND DOLLAR: Beachview Drive, N., Jekyll Island, Ga. 31520
$34 One Bedroom Townhouse (two persons); $43 Two Bedroom Townhouse (four persons); $49 Three Bedroom Townhouse (six persons)
Roll-away beds $4 per day.
Each townhouse consists of bedroom(s), living room, dining room and kitchen.

MEDICAL ASSOCIATION OF GEORGIA
April 9, 10, 11, 1976

TO ..... 1st choice
(hotel name)
..... 2nd choice
(hotel name)

Please reserve the following accommodations in my name for arrival

..... (date), at ..... (time) am pm, and departure ..... (date) am pm.

Type of accommodation ..... for ..... # persons.

List additional occupants:

....
....

Please mail a confirmation of these reservations to:

Name .....

Address .....
.....



Enjoy Jekyll Island . . .

THE ISLAND'S rich history includes the Creek Indians who fished and farmed the region. In 1566 Spanish friars joined them, hoping to claim the land and convert the natives. Pirates, preying on coastal shipping, buried their treasures here during the 1700's and in 1736 Georgia's founder, James Edward Oglethorpe, honored one of his sponsors, Sir Joseph Jekyll, by naming the body of land after him. One of Oglethorpe's aides, Major William Horton, built a home here and established a successful farm and brewery. The ruins of this house are open to the public in the northern part of the island.



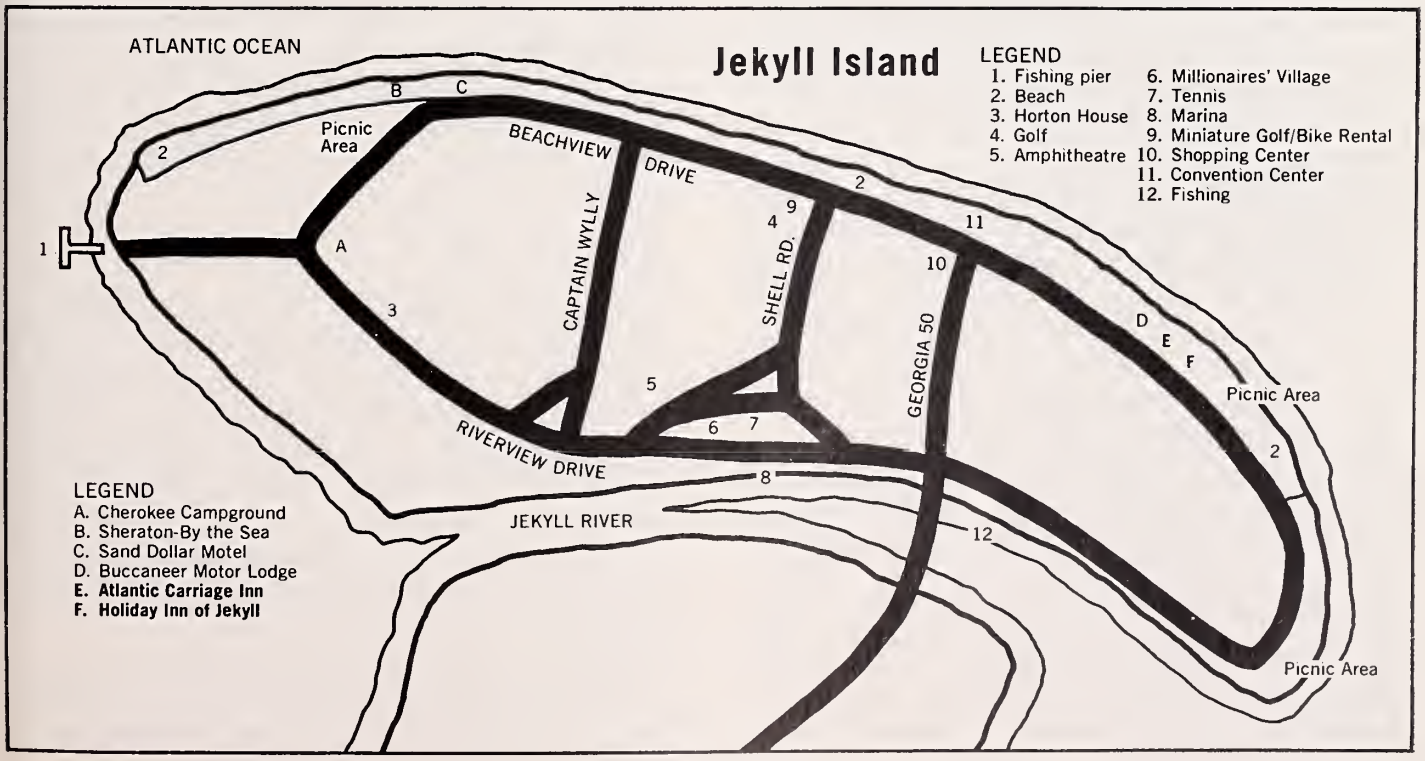
During the Nineteenth Century an active plantation was run on Jekyll by a prosperous French family, the DuBignons. Then in 1886 a group of wealthy American families took advantage of the climate and natural beauty buying Jekyll Island for their exclusive winter retreat. Visit Millionaire's Village for a glimpse of late-Victorian living. The island was purchased by the State of Georgia in 1947 and now can be reached by causeway from Brunswick, by boat through the intracoastal waterway system or by private aircraft landing on its own paved airstrip.



Recreational needs are well met with golf, tennis, boating, fishing, swimming and picnicking facilities abundant. Expect a daily average temperature in the high 60's for April.

During your stay you may want to wander up the coast a few miles to see additional historic places on Saint Simons Island. Arrange with the Coast Guard to visit the top of the tower of Saint Simons Lighthouse, rebuilt in 1871, affording a good view of the ocean, islands and rivers. An adjacent museum is operated by the Coastal Georgia Historical Society. Also on the island is Fort Frederica National Monument built by Gen. Oglethorpe in 1736 and the most expensive British fortification in America at the time.

Photographs courtesy the Tourist Division of the Georgia Department of Community Development.



An assessment of acute lethality which is rapidly responsive to therapy or environmental change.

The Determination of Dangerousness

W. DOUGLAS SKELTON, M.D., *Atlanta**

Correctional agencies, courts, and now mental health agencies are increasingly under pressure to "do something" about violence. Chapter 88-5 of the Georgia Health Code describes the procedures for hospitalization and release of mentally ill persons. The criteria for involuntary commitment is that the person "appears to be mentally ill and is likely to injure himself or others, and the observations upon which that conclusion is based."

There are innumerable conflicts related to the application of this statute. Courts, law enforcement officials, private physicians, and family members complain that patients whom they believe to be dangerous are either not admitted or are prematurely discharged from the regional mental hospitals. The medical staff of the regional mental hospitals complain that patients are sent for involuntary hospitalization without any documentation that the patient is dangerous, that some patients are being committed to "relieve the family of a burden" or for even less humane reasons, i.e., as a vindictive act or an effort to gain control of the patient's resources. Patients claim they are being illegally deprived of their freedom, file legal actions seeking release, and threaten or file personal damage suits against physicians. In view of these conflicts it is important that all Georgia physicians have an understanding of the complexity of a medical diagnosis of dangerousness.

The determination of dangerousness is fraught with difficulty. It is basically a clinical decision not a statistical one. However, there are certain studies that should be known by clinicians so that the evaluative process is tempered with the proper degree of humility. I shall review three of these studies before proceeding to describe the clinical assessment.

In an article entitled "The Diagnosis and Treatment of Dangerousness," Kozol, Baucher, and Garofalo state that dangerousness in criminal offenders can be readily diagnosed and effectively treated with a recidivism rate of 6.1 per cent.[1] This 10 year study involved 592 male convicted offenders. Most had committed sex offenses and in several there was extreme violence including murder, manslaughter, assault with intent to kill, and assault with a dangerous weapon.

Some 304 of the offenders were diagnosed as not dangerous. Twenty-six (8.6 per cent) subsequently committed serious assaultive crimes. Another 275 offenders were diagnosed as dangerous. These 275 were handled in two different ways. Some 226 of the diagnoses were concurred in by the courts and these offenders were hospitalized for treatment. A group of 82 of the 226 received an average of 43 months of treatment and were discharged on recommendation of the staff as no longer dangerous. Five (6.1 per cent) of this group subsequently committed serious assaultive crimes, including one murder. Forty-nine of the 226 hospitalized patients were released by court order against the advice of the clinical staff. Of this group, 17 (34.7 per cent) subsequently committed serious assaultive crimes, including two murders.

The authors conclude that "no tests or psychiatric examinations can dependably predict a probability of dangerous behavior in the absence of an actual history of a seriously violent assault on another person." Even with this caveat, the crucial finding is that of the 49 patients with a violent history who were released by court order despite a diagnosis of dangerousness 65.3 per cent (42 patients) committed no serious assaultive crime in approximately five years of freedom.

Baxstrom Decision

The Baxstrom Decision (Baxstrom had been detained past the maximum length of his sentence in Dannemora State Hospital, a mental hospital run by the Department of Corrections for convicted felons) resulted in the transfer of 967 patients from correctional hospitals to 18 civil facilities for the mentally ill. These patients had all been previously certified as too dangerous for civil hospitalization by psychiatrists of the New York Department of Mental Hygiene.

Patients released due to the Baxstrom Decision fared much better than people expected.[2] In four years 49 per cent of these patients were released to

* Director of the Division of Mental Health for the Georgia Department of Human Resources, 47 Trinity Avenue, S.W., Atlanta, Georgia 30334.

the community, and only 20 per cent of the total group had any record of assault on hospital, aftercare, or criminal records.

The 20 per cent record of assault is not the important figure. Those who believe dangerousness can be determined must deal with the glaring, overriding, crucial fact that 80 per cent of the group had no record of assault.

The last study to be reviewed is "Can Violence Be Predicted?" authored by Wenk, Robinson, and Smith.[3] The authors studied 4,146 California Youth Authority wards. The focus of the study was on actual violence, usually assault. Predictors were sought from elaborate case histories including such items as past behavior (alcohol use, drug use, suicide attempts, homosexuality, escape attempts, weapons carrying, and past or present diagnosed conditions). Psychological tests were reviewed as well as prognostic judgments regarding academic and vocational potential. The attempt was to construct a device for assessing potential assaultiveness with sufficient accuracy for program decisions.

A history of actual violence was the best predictor. California Youth Authority wards with a history of past violence showed a violent recidivism rate three times greater than a matched sample of non-violent wards. However, this information was of essentially no value for program decision-making. If all wards with a history of past violence were subject to special programming (treatment) the program directors would be sounding a false alarm 19 times in 20 and wasting 95 per cent of the resources expended in the endeavor.

Crisis Situations

The authors conclude that the problem of prediction is fundamentally related to the nature of the phenomenon studied. Violence is a low probability behavior. In looking at 104 incidents of violence in this study the authors concluded that the violent act erupted out of a crisis situation.

These studies lead to a conclusion that the restriction of individual liberty based on a diagnosis of dangerousness should occur only in the context of an evaluation of the crisis situation in which the individual is involved. The definition of dangerousness in this context is a recognizable, or diagnosable state of readiness to do harm to others. The factors that I consider important in making this determination are as follows:

I. Factors lowering self-control.
   A. Mental retardation and/or organic brain disease may reduce the patient's capacity to understand the full significance of his behavior and to consider alternative ways of handling stress.
   B. Alcohol is clearly associated with violent behavior.[4] It is a factor in 50 to 90 per cent of homicides.
   C. Amphetamine abuse may lead to violent acts.[5] This is especially true on a "speed run" with a daily dose of 800 to 1000 milligrams. With increased dosage, all patients develop a toxic amphetamine psychosis with persecutory delusions, and may respond in violent fashion toward their assumed persecutors.
   D. Personality and psychotic disorders with marked paranoid ideation may influence patients to respond violently toward their imagined enemies. Acute catatonic excitement may include acts of violence. Depressed patients who blame others for their misfortune may retaliate in an aggressive fashion.

II. Historical Factors of Importance.
   A. Past assaultive behavior.
   B. A history of repeated auto accidents has been associated with future homicidal and suicidal behavior. Some clinicians are especially concerned if there has been a history of using the automobile as a weapon.
   C. Some years ago a triad of cruelty to domestic animals, fire-setting, and enuresis was reported as associated with violent acts.[6] Most clinicians with whom I have worked consider cruelty to domestic animals and fire-setting as more pathological than enuresis.
   D. A history of rage reactions following separation from significant others.
   E. An attraction for guns and knives has appeared in the histories of subsequently violent individuals.
   F. Physical abuse as a child has been associated with assaultive behavior as an adult.[7]

None of the above is sufficient to make a diagnosis of dangerousness involving the limitation of a person's freedom. The most important part of the assessment is the evaluation of the current situation. How dangerous is this person now?

Assessment, Then Treatment

The evaluation is handled in much the same way as the evaluation of suicidal potential. The majority of potentially dangerous persons will respond to these questions. For the most part they are frightened by their own inability to control their acts and are desperate for someone to offer them assistance. The patient should be asked if he fears becoming destructive or suddenly responding to an impulse. The questions are then directed at the degree of lethality. How would you do it? Do you have a weapon?

Have you engaged in any preparatory actions (loading the gun, pointing it at someone)? The issue is to what extent does the patient regard violence as a solution and what alternative solutions are being considered. Whether significant others, i.e. family, friends, employer, acquaintances, exacerbate or reduce the conflict must be considered. I agree with Kozol and others that a state of impotent despair, i.e. "there is no way out" is of prime importance.

Treatment decisions logically follow the assessment. A change in environment may reduce the intensity of the conflict. This may involve the arrangement of another living facility or in certain acutely dangerous situations may require the use of a closed hospital ward. Major tranquilizers are often helpful. This is particularly true if the patient is psychotic and the medication is specific for the psychotic condition. Medication is less useful with patients suffering personality disorders or involved in acute situational crises. Long-term management is directed to clarifying areas of conflict and developing more adaptive responses through a variety of treatment approaches. Voluntary hospitalization and/or environmental change should be encouraged as an appropriate response during recurrent episodes.

In closing I want to stress that I have described assessment of acute lethality which is rapidly responsive to therapy or environmental change. Longer term prediction of violence is not supportable by data at this time. False confidence in our predictive capacity may well serve to legitimatize social control. The acceptance of the present unsatisfactory state of our non-predictive capacity may lead to data useful for the treatment of the individual and the protection of society. ■

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In the author's experience Prostaglandin F_2 alpha would appear to be safer because of the absence of serious side effects.

A Comparison of Saline and Prostaglandin Abortions at the Medical Center of Central Georgia

JACOB R. HARRISON, M.D. *and* JOHN A. SOUMA, M.D., *Macon**

PROSTAGLANDIN F_2 ALPHA (Prostin†) is available for use in mid-trimester abortions, and is reported to be a safe and effective abortifactant. This study compares our experience with hypertonic saline and Prostaglandin as abortifactants.

Methods and Materials

1. *Saline Abortions:* Hypertonic saline abortions are performed after initial evaluation of CBC, urinalysis, VDRL, Gonorrhea culture, blood type and cross-match. An amniocentesis is performed with an 18 or 20 gauge spinal needle and a free flow of amniotic fluid is established. Ten ml. or less is removed and a volume of between 180-120 ml.'s of 17½ per cent saline is injected. Repeat injections are done if the abortion has not commenced within 24 hours. An infusion of Oxytocin is frequently started after spontaneous rupture of membranes. Laminaria tent (Dilateria) is used infrequently.

2. *Prostaglandin Abortions:* After the same initial evaluation, and premedication with an antiemetic, usually Hydroxazine 100 mg. I.M., an amniocentesis is done with a 18 or 20 gauge needle under sterile conditions. After clear free flow is obtained, 40 mg. (8 ml.) of Prostaglandin (Prostin F_2 alpha) is injected into the amniotic cavity. If the abortion is delayed for 24 hours, a repeat amniocentesis is done with an injection of 20 mg. of Prostaglandin. Following all Prostaglandin injections, a vaginal examination is done and a Laminaria tent (Dilateria) is inserted into the cervical os after a Betadine prep. The Laminaria is removed either at the time of abortion or 24 hours after insertion. Oxytocin is usually used in this group.

TABLE 1

	Prostaglandin Range	Prostaglandin Average	Saline Range	Saline Average
Age	10-38	20.4	13-37	19.5
Estimated weeks gestation	14-20	17.4	14-22	18
Gravidity	1-6	1.9	1-4	1.7
Injection-Abortion interval (hours)	5.5-57	18.7	10.5-47.5	27.8

Results

Both abortion groups are comparable as to age, gravidity and estimated length of gestation. The injection-abortion interval comparison between the two series, is statistically significant ($p = .05$). No serious complications were encountered in either group.

In the Prostaglandin abortions, gastrointestional side effects were minimal.

Discussion

The injection-abortion interval of our saline group, 27.8 hours, is comparable to other groups reported in the literature. Karenyi[2] reported an injection-abortion interval of 22.5-25 hours in 5,000 saline abortions. Stim[4] reported an injection-abortion interval of 30.9 in 612 cases.

The injection-abortion interval of our Prostaglandin group, 18.7 hours, is comparable with others reported in the literature. The monograph by Upjohn[3] cited a mean injection abortion interval of 22 hours with a range of 4-54 hours and an incomplete abor-

* Dr. Souma is Director of Obstetrics and Gynecology at The Medical Center, P.O. Box 6000, Macon, Georgia 31208. Dr. Harrison served his residency at The Medical Center and now is in private practice in Dalton.

† Trademark by Upjohn.

tion rate between 12 and 23 per cent. A study by Corson[1] compared five different dose schedules and the group which most closely corresponds to our series has an injection-abortion interval of 21 hours.

Our incomplete abortion rate of 30 per cent is slightly higher than other studies. We feel that this is probably a result of our aggressive management to terminate the pregnancy within 2-3 hours of the passage of the fetus.

Our study is a retrospective comparison study of two different mid-trimester abortion methods. Some variables have not been controlled, however, the two groups are similar and the injection-abortion interval difference is statistically significant. The major difference in the two groups is the routine use of Laminaria in the Prostaglandin group versus the occasional use in the saline group. Oxytocin is used sporadically in both groups.

Conclusions and Comments

It is our feeling that Prostaglandin F_2 alpha (Prostin) is a safe and effective abortifactant. The injection-abortion interval is relatively short and in our experience is comparable to other Prostaglandin studies and shorter than studies using hypertonic saline. We feel that the absence of serious side effects (such as coagulopathies and the sequelae of intravascular injection) of hypertonic saline is the main indication for using this drug. ■

TABLE 2

COMPLICATIONS

	% Prostaglandin	% Saline
Retained products of conception requiring D & C	30	16
Re-injection	5	0
Gastrointestinal	8	0
Excessive bleeding	0	0

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ALTANTA GRADUATE MEDICAL ASSEMBLY EXAMINES CONCEPTS AND CONTROVERSIES

Concepts/Controversies is the theme of the 1976 Atlanta Graduate Medical Assembly March 14-17 at the Omni International Hotel. Planners hope the Assembly will "present opposing views of old controversies and new concepts in medical care as they affect the practicing physician."

Eleven specialty societies and health organizations are participating in the annual continuing education event that will earn participants Category 1 credit toward the AMA's Physician's Recognition Award and 23 hours of prescribed credit for the American Academy of Family Physicians.

Alumni and specialty society social events are planned in conjunction with the meetings, and exhibits will be on display. A program for the spouses will include a brunch and fashion show at the Omni International Hotel Monday, and a sightseeing tour is scheduled for Tuesday, with buffet lunch with the Wits End Players of the Sheraton Biltmore, followed by shopping at Lenox Square and Phipps Plaza.

Executive Committee for the Assembly includes: Judson L. Hawk, Jr., general chairman, Alton V. Hallum, Jr., William C. Waters, John P. Wilson, Dan Burge and Wynnell S. Hopkins, who is executive secretary. Programs and registration forms are available from the Atlanta Graduate Medical Assembly, 875 W. Peachtree St., N.E., Atlanta, Ga. 30309; telephone (404) 351-6661.

A brief review of the program by specialty with speakers and dates follows.

ORTHOPEDICS: (Sunday, March 14) Frank H. Stelling, Jr., Shriner's Hospital, Greenville, S.C.

CARDIOLOGY: (Monday, March 15) Kenneth H. Cooper, The Institute for Aerobics Research, Dallas; Meyer Friedman, Harold Brunn Institute, Mount Zion Hospital, San Francisco; Herman K. Hellerstein, Case Western Reserve University, Cleveland; Robert A. Kreisberg, University of South Alabama.

INTERNAL MEDICINE: (Tuesday, March 16, and Wednesday, March 17) Ronald A. Arky, Harvard; Thomas R. Hendrix, Johns Hopkins; John H. Laragh, Cornell Medical Center; James C. Melby, University Hospital—Boston; James Moss, Georgetown University; Howard M. Spiro, Yale.

PERINATOLOGY: (Monday, March 15) Frank H. Boehm, Vanderbilt University Hospital; L. Joseph Butterfield, University of Colorado; Douglas W. Cudmore, Dalhousie University, Halifax, Nova Scotia; Stanley N. Graven, University of Wisconsin; Edward H. Hon, University of Southern California Medical Center; H. Belton P. Meyer, University of Arizona.

HUMAN SEXUALITY: (Wednesday, March 17) Oliver Bjorksten, Medical University of South Carolina.

GENERAL SURGERY/CANCER: (Monday, March 15, and Tuesday, March 16) Walter F. Ballinger, Washington University; John M. Beal, Northwestern University; Robert E. Hermann, Cleveland Clinic; Loren J. Humphrey, University of Kansas; Richard B. Stark, Columbia University.

VASCULAR SURGERY: (Wednesday, March 17) John J. Bergan, Northwestern University; John H. Foster, Vanderbilt University; Georgia C. Morris, Jr., Baylor College of Medicine.

In its brief existence, this consortium has proven itself to be a practical and viable force in the Atlanta health community.

Cooperative Library Services for Atlanta's Hospitals

STEPHEN M. KOPLAN, CATHERINE J. CHEWNING *and*
JANE BUMGARNER, ***Atlanta****

AESOP'S FABLE, "The Bundle of Sticks" has a valid basis in the health science library. In the story, a father whose sons are quarreling takes several sticks and ties them into a bundle. Each son is then asked to break the bundle in half. None can do so. The father then unties the bundles and asks his sons to split each stick. The latter find this an easy accomplishment. The moral of the story is that a united effort will produce a stronger result than an individual one. Libraries today are employing this concept to improve their services. Rising economic problems coupled with ever increasing library needs due to the "information explosion" require that librarians look beyond immediate boundaries to supply necessary services.

Cooperation among libraries is not a new idea. Interlibrary loaning and borrowing of books and journals have been going on for many years on an irregular basis. In addition to this type of association, structured academic library networks have existed throughout the country. Examples include the New England Library Network (based in Boston) and the Ohio College Library Center (based in Columbus).

Nationwide medical library networks, called Regional Medical Library Programs, consist of major medical center libraries in each of eleven specially created geographic regions. Georgia is part of the Southeast Regional Medical Library Program (SERMLP) headquartered at Emory University in Atlanta. This program serves the states of Alabama, Florida, Georgia, Mississippi, South Carolina and Tennessee as well as the Commonwealth of Puerto Rico. At least one medical school facility from each of these locations participates. Among the services offered by SERMLP are document delivery, supervision of library applications for federal grants and sponsorship of continuing education courses.

* Mr. Koplan is assistant to the director of libraries of the Georgia Mental Health Institute, 1256 Briarcliff Road, Atlanta, Ga. 30306 and chairman of the Atlanta Health Science Libraries Consortium. Mrs. Chewning is the assistant librarian of the Southern School of Pharmacy at Mercer University in Atlanta and vice chairman of the Consortium. Mrs. Bumgarner serves as librarian at Piedmont Hospital in Atlanta and secretary of the Consortium.

Dependence on Larger Libraries

While programs such as SERMLP support the sharing of informational wealth, they continue to allow small-to-medium sized health science libraries to be dependent upon larger libraries affiliated with major medical facilities. Practically speaking, this approach to inter-library association also causes a drain on the resources of the larger libraries. Thus, instead of utilizing each other's resources, smaller libraries merely increase their demands on those of the larger facilities.

As an alternative to this negative outcome, groups of small-to-medium sized libraries have joined forces and organized into consortia. A consortium is a gathering of persons or institutions for mutual benefit. In this case, libraries join together to share resources and services. One successful demonstration of this concept is the Consortium for Information Resources of the West Suburban Hospital Association formed in 1973 near Boston to coordinate the library services of various community hospitals. Their cooperative library projects have included production of a consolidated list of periodicals received by the participating libraries, installation of a MEDLINE terminal, and other projects beneficial to library consumers.

A program similar to that in Boston has been formed by health science librarians from metropolitan Atlanta. Prior to this action, they had become heavily dependent upon the resources of the A. W. Calhoun Library of Emory University to fill their re-

quests for books and journal articles. After a review of the needed items it was felt that much of the borrowing from the Calhoun Library could have been done amongst the smaller libraries in the area. For example, the more commonly held journals such as *New England Journal of Medicine* and *JAMA* were available from local sources other than Emory. Furthermore, journals less easily available could be obtained, when necessary, from some of the specialized libraries and shared among consortium members. In this way, a balanced library service system utilizing complementary resources would be created.

With these concepts in mind, a group of seven health science librarians met in October, 1974 to form the Atlanta Health Science Libraries Consortium. Institutions represented included the Georgia Mental Health Institute, Southern School of Pharmacy of Mercer University, Piedmont Hospital, Georgia Baptist Hospital, St. Joseph's Infirmary, DeKalb General Hospital and Northside Hospital. These were later supplemented by the Georgia Baptist Hospital School of Nursing, the Georgia Department of Human Resources, the Atlanta Veterans' Administration Hospital, the Georgia Retardation Center, the Emory University School of Dentistry and the Yerkes Primate Center. Unlike their counterparts in Boston, the cooperative effort initiated by the Atlanta librarians was administratively independent from their institutions. It was hoped that a common concern for various problems would be enough to produce a unified effort.

Threat from Copyright Bill

One immediate problem which drew all the librarians together was their concern about a pending copyright bill (S. 1361, Sec. 108, G(2)) to make "systematic photocopying" illegal. Due to the ever increasing amounts of information published and the constant rise in its cost, it has been found practical to photocopy an article requested from one library by another. Otherwise, it would be necessary to mail or transport the needed volume to the requesting library or force libraries to increase costs and use valuable research time asking publishers' permission to photocopy articles. With such difficulties in mind the ideal initial project for the Consortium was opposition to the copyright bill.

Librarians at each participating library sent a telegram to the Congressman in the district in which the library was located urging him to oppose section 108 G(2). They also contacted influential staff members in each of their institutions and urged them to write letters to their Congressmen. The group's actions were not only useful in solidifying personal contact amongst themselves but also produced a great deal of positive response from those contacted. The librarians were frequently being questioned about the progress of the bill. Clearly, this amount of interaction indicated that there was more than a passing interest in the outcome. The bill has passed the Senate and is pending in the House where it has been numbered HR-2223. Recently the Supreme Court ruled that under the present law libraries can make single photocopies for research or educational purposes. The copyright issue, however, is still a controversial one and the Consortium members will need to keep an eye out for further developments.

As a further step towards the development of an effective Consortium, the librarians from the participating institutions decided to establish a system to enable them to borrow requested material from one another. This, it seemed, would hopefully decrease the marked dependence upon the resources of the A. W. Calhoun Medical Library. Since DeKalb General Hospital was identified as having the smallest collection of journals it had the greatest need to borrow from other Consortium members. Statistics were kept using that hospital's library as a model for determination of intra-Consortium borrowing as opposed to borrowing from the Calhoun Library. The data revealed that approximately half of the inter-library loans from DeKalb General Hospital came from the Calhoun Library and the other half from within the Consortium. The borrowed material would have previously been almost exclusively requested from the former. This seemed to indicate that the member libraries could duplicate as well as complement the resources of the Calhoun collection. The borrowing practice was therefore expanded to include all members.

Periodical holdings lists from most libraries have now been distributed to members in order to make possible easy identification of materials. A single combined list is presently in preparation. This tool should make it both faster and easier to transmit greatly needed information in the Atlanta health services community.

It is hoped that in the future the Consortium will publish a monthly newsletter containing library information of interest to health professionals throughout Atlanta. Other projected Consortium activities include MEDLINE service and a consulting service for newly formed health science libraries in the area. Members of the staff of the A. W. Calhoun Medical Library serve as consultants to the Consortium.

In its brief existence, the Atlanta Health Science Libraries Consortium has proven itself to be a practical and viable force in the Atlanta health community. Similar programs are under consideration

among librarians in Augusta and Rome, Georgia.

Using combined resources health science librarians can meet the expanding "information explosion" and in addition help to maintain fiscal control in a difficult economic situation. The development of consortia will, furthermore help to increase awareness of library activities among health care institutions. It could be argued, of course, that access to some of the literature will be limited if subscriptions are decreased. However, many rarely used titles within the Consortium are now shared by the participating libraries at a fraction of the cost of several individual subscriptions.

Hopefully, these many factors have demonstrated the ever-increasing need for cooperative library programs in health care institutions.

Acknowledgments

We wish to thank the many persons who gave their time and efforts in the preparation of this article. We regret that space does not permit us to list them all by name, particularly the entire Consortium membership. ■

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Administrator

A Large Abdominal Mass With A "Sunburst" Vascular Pattern

VAN COLEMAN, M.D. *and* JOE RUDÉ, M.D., *Atlanta**

DR. VAN COLEMAN: The patient is a 60-year-old female who presented to the hospital with the history of the onset of abdominal pain which was nonspecific in nature and accompanied by nausea and vomiting at the onset. There was a history of weight loss. The patient was found to be anemic and an abdominal mass was palpable. These are the radiographs of the abdomen which were made on admission. Dr. Rudé, would you discuss this case?

Dr. Joseph Rudé: The recumbent and upright films of the abdomen show a nonspecific gas pattern. There is no evidence of abdominal mass that I can identify on these films. How large was the mass and where was its location?

Dr. Coleman: The mass was reported to be approximately 10 x 15 cm. and located in the right side of the abdomen.

Dr. J. L. Clements: A large abdominal mass which is palpable and cannot be identified on plain films is more likely to be within the abdomen than in the retroperitoneal space. The distortion of the retroperitoneal fat by a large mass in this area should make the mass apparent. If the mass is intraabdominal it may not be visible unless there is evidence of distortion or displaced gas-filled loops of intestine. What procedures do you think should be done in an attempt to delineate this mass?

Dr. Rudé: Barium contrast studies of the colon and intestinal tract would probably prove of value in identifying the mass.

Dr. Coleman: Here are representative films of the barium enema and the upper gastrointestinal tract, would you comment on these?

Dr. Rudé: The barium enema shows the colon to be normal in outline and position. There is reflux into the terminal ileum and there is evidence of a mass fixing and distorting the distal ileum near the ileo-cecal valve (Figure 1). There is a circular loop of intestine which appears to be fixed along its medial margin by a mass. The small bowel study also confirms the presence of the mass fixing the distal ileum. The possibilities would include a large inflammatory mass or a neoplastic mass fixing the distal ileal loop. I would favor a neoplastic process.

Dr. Coleman: There was nothing in the patient's history of physical findings to suggest that this was inflammatory in nature. A superior mesenteric arteriogram was then performed for further study of this lesion. This is a representative film from the arteriogram (Figure 2).

Dr. Rudé: There is marked distortion and irregularity of the branches of the ileal-colic artery. They appear to be encased by tumor. The vessels radiating from the area of encasement have a very

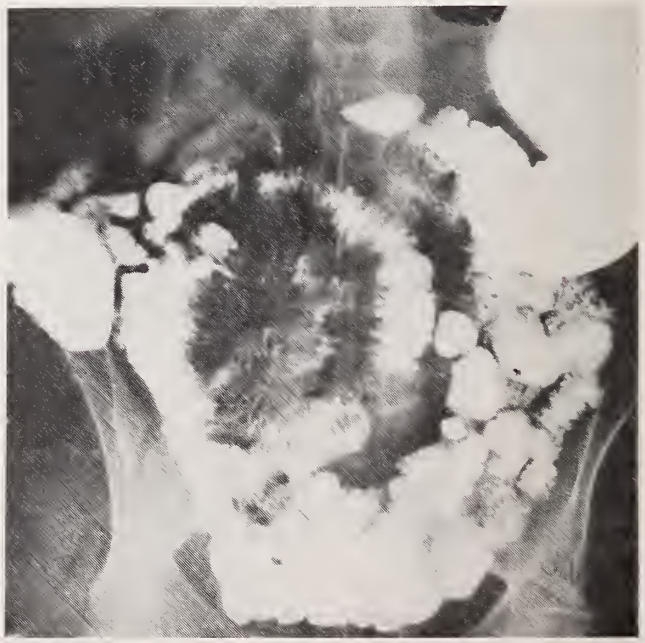


FIGURE 1

Small bowel study showing fixation and distortion of the distal ileum by the mass.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

unusual pattern of peripheral radiation which might be described as sunburst.

The angiogram confirms that this is a neoplastic process. The possibilities would include mesenteric metastases. It has been pointed out that there is a tendency for both carcinoma of the stomach and the pancreas to metastasize intra-abdominally along the course of the mesentery to the right lower quadrant. Direct extension from neoplastic process of ovarian or uterine origin may also produce this pattern. Primary tumors such as lymphosarcoma and leiomyosarcoma should be included in the differential.

Dr. Clements: Are there any other primary tumors of the intestinal tract which have a tendency to occur in this area?

Dr. Rudé: Carcinoid tumors have a tendency to occur most frequently in this area. The gastrointestinal studies and arteriogram are certainly compatible with this possibility.

Dr. Coleman: The sunburst pattern on angiography has been described as being quite characteristic for carcinoid. Retroperitoneal fibrosis may also produce this pattern, however.

The patient underwent abdominal surgery and a large neoplastic process involving the distal ileum was found and was inoperable. There was evidence of nodal metastases. Histological examination of the involved nodes indicated the lesion to represent carcinoid tumor.

Discussion

Carcinoid tumors of the small intestine are relatively infrequent although they have been described as being the most common small intestinal tumor. The most frequent site of origin is the distal ileum. Clinically, the symptoms are generally nonspecific and are often secondary to small bowel obstruction. An abdominal mass may be palpable on physical examination. However, in occasional cases, notably in those with liver metastases, a specific clinical entity, the so-called carcinoid syndrome, characterized by chronic diarrhea, flushing and cyanosis, respiratory distress, and right-sided cardiac disease, is present.

The radiographic findings are related to the growth characteristics of the tumor. Barium studies may demonstrate only an intraluminal filling defect or because of the tendency for carcinoids to invade



FIGURE 2

Superior mesenteric arteriogram demonstrating encasement by the carcinoid tumor. There is marked distortion and irregularity of the branches which radiate from the area of encasement.

the adjacent mesentery and cause extensive fibrosis and adhesions, kinking and angulation of the bowel may be seen. A third common finding is a small bowel obstructive pattern. As the tumor is generally of insufficient size to cause mechanical obstruction, this is usually due to fibrotic and adhesive changes and occasionally to intussusception of intraluminal masses.

Angiography has become a useful method for diagnosing infiltrating carcinoid tumors preoperatively because carcinoid involvement of the small bowel and mesentery presents a typical angiographic pattern. The marked fibrotic reaction is responsible for many of the angiographic features which include a stellate pattern of the mesenteric arterial branches, narrowing of the deep mesenteric arterial branches, poor-to-moderate accumulation of contrast material, and lack of filling of draining veins. ■

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Welcome to Jekyll Island

THE GLYNN COUNTY MEDICAL SOCIETY is honored to host the annual session of the MAG House of Delegates on Jekyll Island April 9-11, 1976.

Brunswick and the Golden Isles abound with historical and recreational sites. Miles of beautiful white sand beaches are waiting to welcome you to St. Simons Island, Sea Island, and Jekyll Island. Abundant golf courses of championship quality are available in Brunswick, Jekyll and St. Simons Islands.

The heritage of General Oglethorpe can be viewed at the many historical sites on St. Simons Island and Jekyll Island's "billionaire's village" depicts an era of splendor of the late 1800's.

Richard W. Egan, M.D.
President
Glynn County Medical Society
2432 Parkwood Orive
Brunswick, Georgia 31520

Heart Month: Emphasis on Risk Factor Modification

EXCITING ADVANCES have occurred in the treatment of heart disease in the past decade. Many times, however, the best treatment constitutes palliation, while the real answer is prevention.

The Georgia Heart Association, an alliance of medical and non-medical volunteers, is making a major effort to promote prevention of heart disease through a program emphasis of risk factor modification.

Georgia is a national leader in detection and treatment of hypertension, a major risk factor. The Georgia Heart Association has been a catalyst through public and professional education, support of screening and treatment centers, and a unique program of teaching grade school children to take blood pressures of families and friends.

There is no longer any question regarding the primacy of cigarette smoking as a risk factor for acceleration of atherosclerosis. The GHA plans to continue educating the public regarding this hazard and to make a special effort to introduce into the public school system a "heart health" curriculum using innovative methods to teach risk factors, including the danger of smoking.

The statistics linking elevated blood lipids and increased risk of atherosclerotic complications seems valid. Prudent dietary modification is in order,

and with the help of professional dietitian members of the GHA, this message is being brought to the public—again with emphasis on our young people.

Recent figures suggest that primary prevention may be making in-roads in the mortality of atherosclerotic heart disease, and we ask all physicians to join the GHA in fighting the "Number One Killer."

C. Daniel Cabaniss, M.D.
President
Georgia Heart Association
P.O. Box 951
Columbus, Georgia 31902

COBB SYMPOSIUM EXPLORES THE CHANGING FAMILY

Dr. Joyce Brothers will headline the 11th Annual Cobb County Symposium April 1-2, 1976, with an appropriate theme, "The Family in America 1776-1976."

The annual interdisciplinary program is planned and sponsored by the Cobb County Medical Society, the Cobb Judicial Circuit Bar Association, Kennesaw Junior College and the Cobb County Ministerial Association.

Dr. Brothers, a well-known psychologist, newspaper columnist and television personality will speak at the closing dinner session Friday night, April 2 at the new Peachtree Center Plaza Hotel. Her topic is "The Family in America—200 Years of Change."

Dr. John R. Silber, president of Boston University, will open the Symposium Thursday evening at Kennesaw Junior College speaking on the "Value of the Family and Future Possibilities." Speakers for the Friday session will be: The Honorable Judge Lisa Richette of Philadelphia, Pa., "Law and the Family"; The Rev. Dr. Kenneth R. Mitchell, director of the Division of Religion and Psychiatry of the Menninger Foundation, "Whatever Happened to Marriage"; Dr. Anna Grant of Morehouse College, "The Black Family in America"; and Leonard Cohen of Atlanta, "The Jewish Family in America." The program will close with a panel discussion with all speakers, followed by several group discussions with the speakers in the afternoon.

The American Academy of Family Physicians has approved the program for six and one half elective hours. Further information is available by contacting the Office of Community Services, Kennesaw Junior College, Marietta, Ga. 30061, or by calling (404) 422-8770.



Brothers



Silber



Richette



Mitchell



Grant



Cohen

heart page
heart page
heart page

Hypertension as a Risk Factor in Coronary Heart Disease

HARRY T. HARPER, III, M.D., *Augusta**

The late Dr. Samuel Levine noted in 1929 that "A previously existing hypertension is probably the most common single etiological factor in the development of coronary thrombosis."[1] Hypertension accelerates and aggravates the process of atherosclerosis. Certain nutritional-metabolic prerequisites are apparently necessary for this to occur. This appears to be the reason why hypertension is a significant risk factor in this country but not in some other populations. For example, in the mass of Japanese and Bantu South Africans hypertension, which is widely prevalent, is not associated with a marked increase in coronary heart disease (CHD). These people habitually ingest a diet low in sugar, fats, and cholesterol. Studies in animal models also indicate that atherosclerosis develops more rapidly and is more severe in hypertensive animals fed an atherogenic diet than similar animals fed a normal diet.[2]

The actual mechanism by which hypertension aggravates atherosclerosis has not been established. There is considerable evidence that this is due, at least in part, to the direct mechanical effects of a high level of arterial pressure on the arterial wall. An example which provides strong support for a mechanical effect of hypertension on the structure and metabolism of the arterial wall is coarctation of the aorta. In this abnormality, the atherosclerotic lesions are distributed almost exclusively in the high pressure portion of the aorta above the coarctation whereas the distal low pressure segment remains relatively free.[3]

Rule of Halves

It is estimated that some 26 million Americans have hypertension. A rule of "halves" has evolved from surveys which show that approximately half of those who have hypertension don't know it; only half of those who are aware of it are under treatment; and of those under treatment only half are adequately controlled. The disease is more prevalent and more severe in Blacks. It is the leading cause of death in the Black population. For every Black who dies of sickle cell disease, 100 die from the ravages of hypertension. The incidence of hypertension is greater in men than women up to about age 50, after which the reverse is true. It is tolerated somewhat better by women. There is suggestive evidence that essential hypertensives with low renin levels are relatively protected from heart attacks and strokes.[4]

Pickering has long emphasized that there is no dividing line between normal

* Dr. Harper's practice in cardiovascular disease is located at 310 Medical Arts Building, 1467 Harper Street, Augusta, Ga. 30902. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

and abnormal blood pressure. This is especially true in regard to hyptertension as a risk factor. The risk of CHD is simply proportional to the level of blood pressure, either systolic or diastolic.[5] This is clearly indicated by life insurance statistics as well as other studies. The higher the blood pressure, the greater the risk. The relationship is quantitative. In the Framingham Study, hypertension was arbitrarily defined as a systolic pressure of 160 or greater or a diastolic pressure exceeding 95 obtained on two examinations. There was, in fact, a stronger association of systolic pressure than diastolic pressure with risk of CHD. Kannel concluded that "Neither the systolic and diastolic pressure in combination nor the pulse pressure and the mean arterial pressure measurements alone discriminated better than the systolic pressure alone."[5] It was found that for ages 39-59 years at entrance into the study a systolic blood pressure over 160 was associated with a fourfold increase in the risk of developing CHD.

Results of Slight Elevations

Hypertension does not have to be severe to increase the risk of CHD. Life insurance company studies of hypertension, which go back to 1925, indicate that even slight elevations in blood pressure above average are associated with a distinctly higher mortality than among people insured at standard premium rates. Findings from the Build and Blood Pressure Study which covered the experience of 26 large life insurance companies and some 4,000,000 policies issued indicated that a casual blood pressure of 140/90 in men under age 40 is associated with an extra mortality of about 75 percent. In men over age 40, the extra mortality is about 45 percent. The corresponding figures in women were 50 and 25 percent respectively. In men under 40 years of age a casual blood pressure of 150/100 is associated with an extra mortality of 225 percent (mortality from all causes). The mortality from CHD associated with a blood pressure of about 160/95 was approximately two and half times normal for men and about three and a half times normal for women. These findings are considered especially meaningful in that these persons were essentially free of other impairments.[6]

In the National Cooperative Pooling Project findings show that for white men age 30-59 years at the time of entry into the study diastolic blood pressures of 105 and higher are associated with an incidence of first major coronary events that is about four times as high as for men with diastolic pressures under 75. The incidence for men with diastolic pressures of only 85-94 was almost twice that of those with diastolic pressures under 75.[6, 7]

Risk Factors Comparison

Of the three major risk factors in the Framingham Study, systolic hypertension of 160 or more in the age group 45-64 years, had a higher relative mortality rate from CHD than did a serum cholesterol of 280 and higher or smoking more than 20 cigarettes per day.[6] The Task Force Report of the American Heart Association on Atherosclerosis and CHD states that "Hypertension is the major remedial risk factor."[8]

Hypertension places a burden on the left ventricle by increasing myocardial wall tension and oxygen consumption. These effects may precipitate or aggravate symptoms in persons with known CHD. A recent study indicates that patients with CHD and borderline or established hypertension have a higher mortality rate than normotensive patients with CHD.[3, 9]

Hypertension, of course, is a very strong risk factor in other cardiovascular disease besides CHD such as stroke, congestive heart failure, renal disease and dissecting aneurysm. It is beyond the scope of this brief résumé to discuss these other known complications of hypertension, either from the standpoint of risk involved or benefits of treatment. Suffice it to say that evidence available at this time indicates that treatment of hypertension is more beneficial in preventing these complications than in preventing CHD. This makes it even more imperative that hy-

pertension be detected and adequately controlled in persons with this usually asymptomatic but dangerous condition. ■

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William H. Mathews, M.D.
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Emory University School of Medicine

Melvin R. Moore, M.D., Assistant Professor
Division of Hematology/Oncology
Emory University
Director, Interdepartmental Oncology Ward
Grady Memorial Hospital

More on Informed Consent

J. WINSTON HUFF, *Atlanta**

In the January issue of *JMAG* we discussed the "informed consent" rule as it had been reviewed in opinions of the Georgia appellate courts. Since that article was set for printing, two new decisions of the Georgia Court of Appeals have been handed down which clarify the state of the law in Georgia on this subject.

One case was decided in early November of 1975. In this case the plaintiff alleged that the physician had breached his duty to her by failing to advise her that the particular surgical procedure was difficult and involved risks. She contended that the doctor had thereby induced her to undergo an operation to which she would not have agreed if she had been given a full disclosure of the possible consequences. The patient testified that she would never have consented to the operation if she had been informed of the possibility of certain results. The court reaffirmed its previous stand that it had not in the past been definitely decided whether the doctrine of informed consent was applicable in the State of Georgia.

For the basis of its decision the Court turned to the Georgia Medical Consent Law (Code Section 88-2901) which was mentioned in the previous article. This Code section states as follows:

> "A consent to medical and surgical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing and signed by the patient or other person or persons authorized to consent pursuant to the terms hereof, shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining the same."

The Court stated that this law expresses a legislative intent as to the duty of the doctor regarding disclosure to the patient. The Court referred specifically to the portion of the law which provides that the physician should disclose "in general terms the treatment or course of treatment." The Court concluded that this law thus set forth the requisites, and the only requisites, concerning disclosure which are necessary for a valid consent to be obtained from the patient. The Court went on to say:

> "Although the present case is not controlled by this statute in that the consent form did not disclose the general terms of treatment, the statute does express a legislative intent as to the duty of the doctor regarding disclosure in order to obtain a valid consent. It provides that the physician must disclose *in general terms the treatment or course of treatment* in connection with which the consent is given. The legislature thus sets forth the requisite disclosures necessary to render a consent valid."

In a second case decided just a few weeks after the first case the Georgia Court of Appeals again referred to the Georgia Medical Consent Law and held that the

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

only information a physician is required to give is that stated by the law—a written consent signed by the patient disclosing in general terms the proposed treatment or course of treatment. The Court stated that this duty does not include a disclosure of "risks of treatment" and that a physician does not breach his duty to his patient in failing to warn of the risks of treatment.

It should be noted that the Georgia Medical Consent Law requires a consent in writing and also requires that there be no misrepresentation of the facts in obtaining the consent.

Although these cases seem to settle the law in Georgia for the time being, your author still thinks it would be a good idea to discuss the risks with the patient and to make notes in the patient's chart that this has been done, in addition to getting a written consent described in the statute.

HIGHLIGHTS OF COUNCIL

January 10-11, 1976

GRMP: Dr. Gordon Barrow reported on phase-out plans through June 30, 1976 with a skeleton staff on until October 1. Indirect cost paid to MAG since GRMP began in 1968 will total $633,000.

Amicus Curiae Brief: Approved preparation of an amicus brief in suit by parents of a deceased child against an intern in Columbus Medical Center. The appeal court decision seemed to set a new standard for juries to establish negligence.

Computerization of Membership Records: Approved the expenditure of $500 per month for use of computer time to handle MAG membership records.

Medicaid Lawsuit: Received report from legal counsel on delay in the hearing of our suit while the case was consolidated with the Georgia State Medical Association suit and while determination is made on enpaneling two additional judges.

Governor's Medical Malpractice Advisory Council: Received and discussed report with recommendations from Charles D. Hollis, Jr., M.D., Chairman. Reaffirmed MAG support for: 1) changing the statute of limitations to two years except in the case of child, which limitation would go to eight years of age; 2) elimination of the *ad damnum* clause; 3) identification of collateral sources of payment; and 4) voluntary binding arbitration.

PSRO Application: Voted to request HEW to put PSROG's application in suspense since the deadline had been extended to January 1, 1978.

Appointments: Georgia Medical Care Foundation Board of Directors—Second District, Frank R. Miller, M.D., Thomasville, director; Fifth District, John R. McCain, M.D., Atlanta, director, and L. Newton Turk, III, M.D., Atlanta, alternate; Eighth District, Leonard C. Durrence, Jr., M.D., Blackshear, director, and Michel A. Glucksman, M.D., Brunswick, alternate.

Research and Development Department: Received report of receipt of a $25,000 grant from the AMA to study prison health care.

Interspecialty Council: Approved addition of the Georgia Chapter, American College of Emergency Physicians to MAG's Interspecialty Council.

Reorganization: Received report of Committee on Organizations and Functions with three conceptual changes for MAG organization: 1) changing the name of Council to the Board of Directors; 2) restructuring officer positions; electing directors by mail ballot.

Legislation: Took action on proposals: 1) opposition to denial of physicians' use of drug of his choice: 2) supported bill to improve maternity coverage in health insurance policies; 3) supported obtaining needles and syringes by prescription only.

Health System Agencies: Heard progress report on HSA development in Georgia from Gordon Barrow, M.D.

Crawford W. Long Museum: Approved donation of $2,500 to support museum.

MAG Dues: Discussed possible increase in dues to make up for loss of government programs and to meet increased expenses.

MRS. BROWN HANDLES COUNCIL, EXECUTIVE COMMITTEE MEETING DUTIES

Several duties connected with the meetings of Council and Executive Committee now are being handled by Lola Inman Brown, administrative assistant, Administration. Mrs. Brown handles calls of meetings and agendas, attends the meetings, taking minutes and later compiling them. These duties had been handled by Catherine Wooten, who retired as of December 1, 1975.

Mrs. Brown came to the Medical Association of Georgia after six years with the Ira M. Hardin Company as executive assistant to John L. Crawford, chairman of the Board, until his retirement. Her varied background includes six years as a legal secretary and four years as a medical secretary. She has served as secretary to Elbert Tuttle, Jr., M.D., Chairman of the Department of Nephrology at Emory University and John H. Sadler, M.D. of the Artificial Kidney Center.

The Albany native has lived in Washington, D.C., Dallas, Texas and in Atlanta 18 years. She attended Albany High School, Freeman's Business College in Albany and Georgia State University.

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NEW MEMBERS

Bath, Nicholas M., DeKalb—Act—U
755 Columbia Dr., Decatur 30030

Belflower, Estol R., Dougherty—Act—R
P.O. Box 1924, Albany 31702

Brand, Robert L., Richmond—Act—Or
1132 Druid Park Ave., Augusta 30904

Bridges, William Z., Thomas Area—Act—Oph
808 Gordon Ave., Thomasville 31792

Dasher, William B., Jr., Bibb—Act—Or
380 Hospital Dr., Macon 31201

Fadel, Hossam E., Richmond—Act—ObG
MCG, Augusta 30902

Fadel, Skina H., Richmond—Act—Anes
MCG, Augusta 30902

Fleming, Lamar L., MAA—Act—Or
1365 Clifton Road, N.E., Atlanta 30322

Griffin, Joseph W., Jr., Richmond—Act—I
U.S. VA Hospital, FHD, Augusta 30904

Hiner, Jerry L., S. Ga.—Act—FP
116 Hospital Dr., Lakeland 31635

Jones, Norman E., MAA—Act—R
315 Boulevard, N.E., Atlanta 30312

Kelly, Oliver, Muscogee—Act—Anes
404 Doctors Building, Columbus 31901

Lambert, Buford L., Richmond—Act—EM
1350 Walton Way, Augusta 30902

Lowry, Thomas F., DeKalb—Act
2701 N. Decatur Road, Decatur 30033

Marmer, Robert H., MAA—Act—Oph
777 Cleveland Ave., S.W., Atlanta 30315

Miller, Gail D., Richmond—Act—EM
1350 Walton Way, Augusta 30904

Minter, Brenda B., Richmond—Act
Box 55, Gracewood 30812

Nechtman, Carl M., Richmond—Act—OALR
1511 Anthony Road, Augusta 30904

Pike, Benjamin F., Muscogee—Act—I
Columbus Med. Center, Columbus 31902

Rice, Joseph F., Meriwether-Harris-Talbot—Act—I
Warm Springs Hosp., Warm Springs 31830

Strong, James S., Richmond—Act—R
Talmadge Mem. Hosp., Augusta 30904

SOCIETIES

Newly elected officers for the **Second District Medical Society,** chosen at a January 17 meeting, are: F. Morris Davis, Tifton, president; David W. Adcock, Moultrie, vice president; Chappell A. Collins, Albany, secretary-treasurer; J. Dan Bateman, Albany, councilor; Sammie Dixon, Tifton, vice councilor.

The *Bulletin* of the **Muscogee County Medical Society** has begun its 23rd year of publication, with P. C. Graffagnino serving as editor the past 14 years.

A combined family Christmas Party was held by the **Richmond County Medical Society** and its Auxiliary in December with entertainment provided by children of members. New officers installed at the meeting were Tom Douglass, president; Joe Bailey, president-elect; Jimpsey Johnson, vice president; and Charles Wray, secretary-treasurer.

Hugh Setzer, Toccoa, has been elected president of the **Stephens-Rabun Medical Society** and the medical staff of Stephens County Memorial Hospital. Serving with him during 1976 will be Kenneth Conoley as vice president.

Tift County has elected new leadership for 1976: Frank Bowyer, president; Gerald Sapp, president-elect; William King, secretary-treasurer; Robley Smith, delegate to MAG. At the December meeting the society also set up a Grievance Committee to deal with "matters of mutual interest between the public and local physicians." Serving on the committee will be Mikell Karsten, Don T. Smith and Sam D. Dixon. The committee will work to resolve grievances or misunderstandings between members of the public and the medical society.

PERSONALS

First District

The first new physician for Sylvania in 12 years, **Ivey L. (Nicky) Shuman, Jr.** began work January 5. The Savannah native spent his early childhood in Sylvania, attended Georgia Southern College and received a master's degree in nuclear engineering from Georgia Institute of Technology. Dr. Shuman then earned his M.D. degree at the Medical College of Georgia and interned in Savannah. His residency in pediatrics was served in Charlotte, N.C. He is a member of the American Academy of Family Physicians and American Society of Pediatrics.

THE ASSOCIATION / Continued

Third District

Tom Adams, Montezuma, has been elected mayor of that city after serving 25 years as a city councilman.

Fourth District

G. H. Channa, Lilburn, has joined the staff of Holly Hill Medical Clinic in Winder where he will practice pediatrics and internal medicine.

Fifth District

The 1975 Aven Cup Award of the Medical Association of Atlanta has been given to **Joseph A. Wilbur** of Atlanta for his work in the field of high blood pressure detection. Dr. Wilbur is president-elect of the Georgia Heart Association and chief of the Adult Health Unit of the Georgia Department of Human Resources.

Seventh District

New officers of the medical staff of John L. Hutcheson Memorial Tri-County Hospital have been named: **Charles L. Hills,** chief of staff, and **Richard K. Cureton,** secretary. In addition, **William D. Crawley** is chief of obstetrics and gynecology; **Garland E. Kinard** is the representative from family practice; **Andres Alisago** is the representative from anesthesiology, and **Stan Martynski** is member at large.

Robert D. Walter of Calhoun has been elected chief of staff at Gordon Hospital, with **Leroy Rabb** serving as vice chief of staff and **Bill Purcell** as secretary.

Tenth District

Named as acting chairman of the Department of Family Practice at the Medical College of Georgia is **Jon C. Clavert,** who has served as assistant professor of family practice. His M.D. and Ph.D. degrees were earned at Baylor University College of Medicine.

J. Graham Smith, Jr., Augusta, has been named to a three-year term on the National Arthritis, Metabolism and Digestive Diseases Advisory Council of the National Institutes of Health. Dr. Smith is a professor and chairman of the Department of Dermatology at the Medical College of Georgia.

Recently certified in dermatology by the American Board of Dermatology is **G. Stretcher** of the Medical College of Georgia.

DEATHS

William R. Minnich

Atlanta physician William R. Minnich died December 18. Dr. Minnich was a graduate of the University of Georgia and Emory University School of Medicine. His residency was served at Vanderbilt University Hospital and he had practiced internal medicine in Atlanta since 1934.

Dr. Minnich was a Fellow in the American College of Physicians, a member of the First Presbyterian Church of Atlanta and Phi Delta Theta fraternity. During World War II he served as a major in the Army Medical Corps.

Survivors include his widow, Caroline Paullin Min-

(Continued on page 70)

PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

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CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

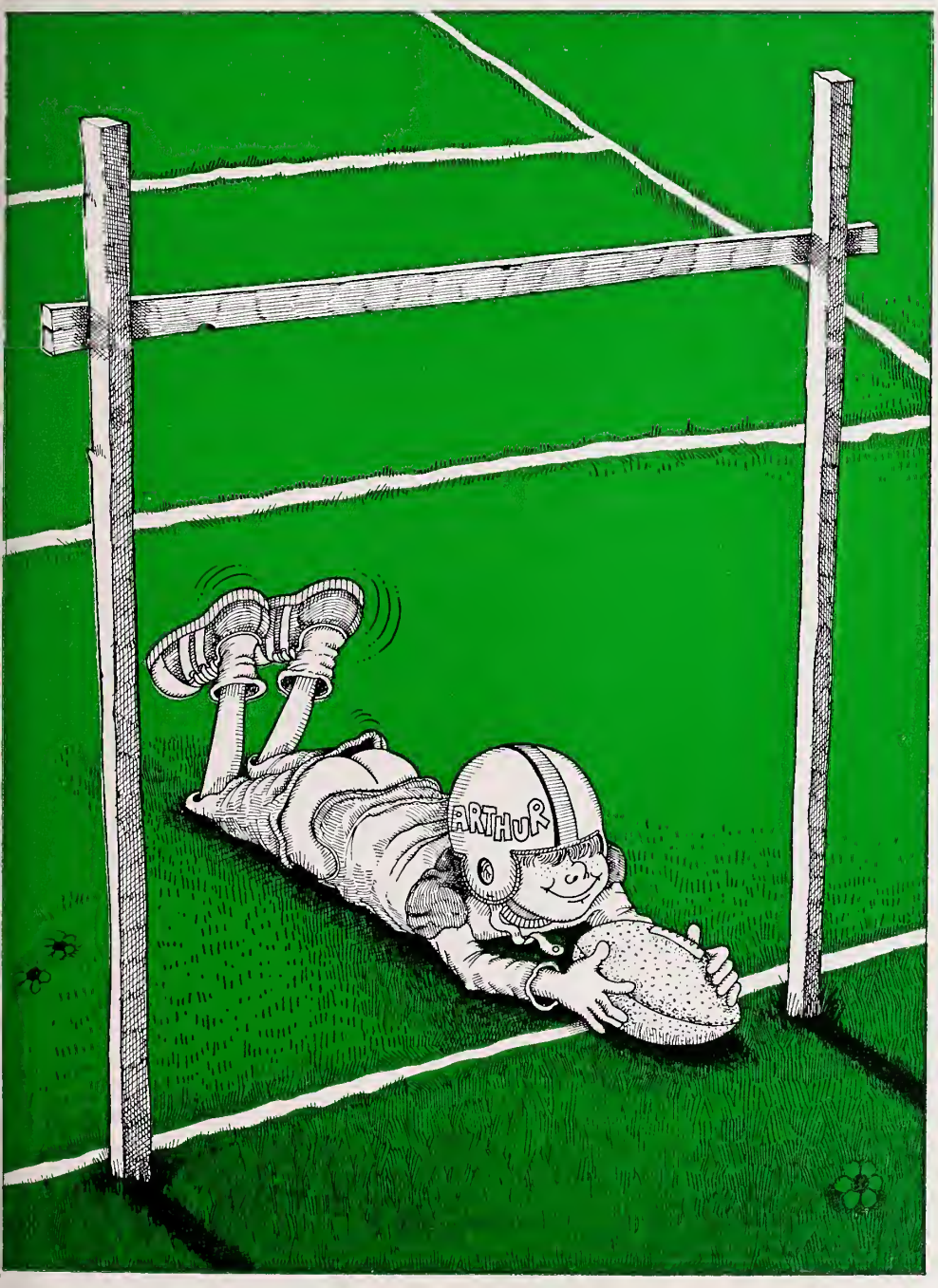
Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

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nich; daughters, Mrs. Brooks S. Lide, Jr. and Mrs. David Watson; son, William R. Minnich, all of Atlanta.

Charles H. Richardson, Sr.

MAG president from 1933-1934, Charles H. Richardson, Sr., died January 3 at the age of 91. Dr. Richardson was an owner of Middle Georgia Hospital from 1918 until it was sold in 1970, serving 20 years as its president and four years as chairman of the board of directors.

Dr. Richardson was born in Byron and graduated from Emory University and the Columbia College of Physicians and Surgeons in New York. He began his practice in Macon in 1911 and was the first chairman of the Macon-Bibb County Health Department when the two were merged in the 1930's. Dr. Richardson was a past president of the Bibb County Medical Society and served as an MAG delegate to the AMA for 10 years.

A founder and past president of the Idle Hour Country Club, Dr. Richardson also was active in the Macon Lions Club and was former director of the Macon Federal Savings and Loan Association. He was a member of Christ Episcopal Church.

Survivors include his sons, Dr. Charles H. Richardson, Jr. of Macon and Stewart S. Richardson of Perry; daughter, Mrs. Edward B. Burdett of Macon.

John G. Wilmer

Atlanta internist and cardiologist John Grant Wilmer died December 18. He was 55.

Dr. Wilmer's undergraduate work was completed at Yale University and he attended Johns Hopkins University Medical School where he did his internship and residency. He completed work in cardiology research at Georgetown University in Washington, D.C.

Dr. Wilmer was on the staffs of Piedmont Hospital, St. Joseph Hospital and Grady, and served as a professor of medicine at Emory University School of Medicine. He was on the Board of Trustees of Oglethorpe University and was the first chairman of Common Cause in Georgia.

Active in Republican politics, Dr. Wilmer once was a candidate for the Georgia House of Representatives. He was nationally ranked in tennis and won the state senior singles and doubles championships.

Dr. Wilmer was a member of St. Ann's Episcopal Church, Piedmont Driving Club and Cherokee Country Club.

Survivors include his widow, the former Mary Charles Fitzpatrick; daughter, Mary Catherine Wilmer of Atlanta; sons, Grant Wilmer, Jr. and Knox Wilmer of Atlanta; father and brother.

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost. Copy and payment should be received by the 20th of the month preceding publication. Mail to the *Journal of the Medical Association of Georgia*, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

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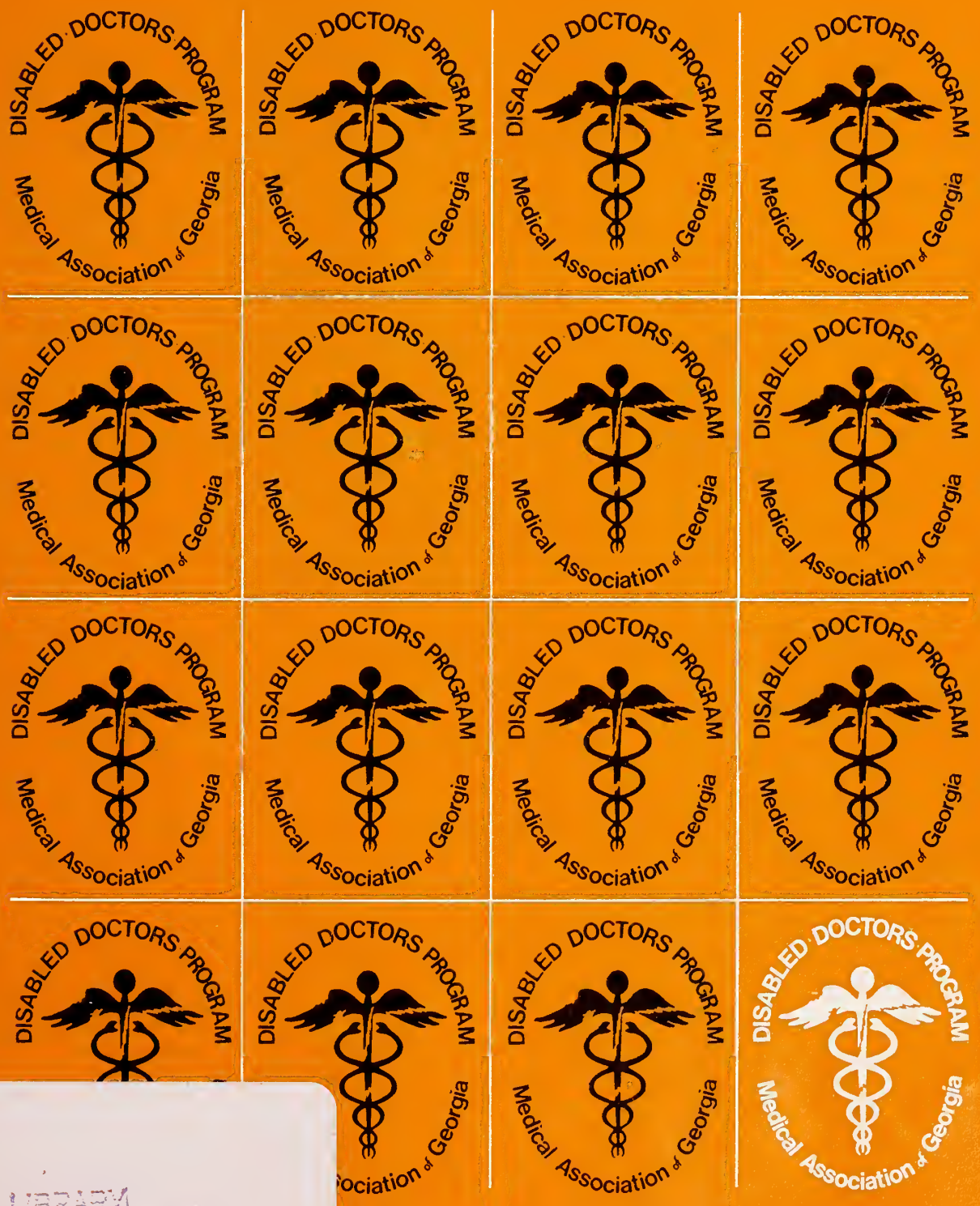
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdr may be associated with temporary increase in frequency and/or severity o seizures. Advise against simultaneous gestion of alcohol and other CNS depr sants. Withdrawal symptoms (similar those with barbiturates and alcohol) h occurred following abrupt discontinua (convulsions, tremor, abdominal and cle cramps, vomiting and sweating). k addiction-prone individuals under car

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THE COVER

This month four articles, an editorial and the Legal Page examine alcoholism among physicians and the Disabled Doctors Plan for Georgia, which already is helping physicians deal with their addictions. The broken caduceus, symbol of the program, was designed by Judie Gray of the Central DeKalb Alcohol and Drug Program. Layout by Bob Hamill, Atlanta.

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The Disabled Doctors Plan for Georgia

G. DOUGLAS TALBOTT, M.D., HANK HOLDERFIELD,
KENNETH E. SHOEMAKER, M.D., *and* EARNEST C. ATKINS, M.D.,
*Atlanta and Decatur**

IN THE GEORGIA PLAN, the term "disabled doctor" refers only to the physician who is addicted to, or is significantly abusing, alcohol or any other mood-changing drug. These disabled doctors have become an urgent problem, not only to themselves, their families, and their patients, but because of the national crisis in malpractice insurance they also pose a serious threat to the hospitals in which they have privileges and the medical societies in which they hold membership.

After months of study, visits to the few states which have already inaugurated some kind of plan to handle this problem, and attendance at the first National Disabled Doctors Conference, which was sponsored by the American Medical Association, the Disabled Doctors Plan for Georgia was drafted. After careful study it was then funded and immediately implemented by the Medical Association of Georgia, becoming operational during the summer of 1975 as a means of assisting the disabled doctor.

The plan is based on two major premises: (1) The disabled doctor, for psychological reasons, is usually unable to reach out for help, no matter how perilous his situation becomes; (2) Fellow-physicians who would help the disabled doctor must take the initiative, being careful to use a sincerely compassionate, non-judgmental, non-punitive approach, and such an approach must be made under the aegis of the state medical association.

Objectives of the Plan

First of all, the plan proposes to identify doctors who are disabled by reason of their addiction to, or abuse of, drugs, including alcohol.

Second, the plan is intended to persuade as many of these doctors as possible to seek treatment voluntarily. During this process it is intended to protect their dignity, preserve their anonymity, and spare them embarrassment to the fullest extent possible. It is also intended to give compassionate assistance to not only the disabled doctor but also to his or her family, from the time of identification until the time that the doctor's professional activities are restored.

Fellow physicians will take the initiative in helping the disabled doctor undertake treatment toward returning to professional activity.

The third major purpose of the plan is to provide a considerate, practical, and effective means of dealing with those doctors whose disability has been verified, but who either continue to deny their illness or else have refused to complete a course of treatment. It is the intention of the Georgia Plan not only to protect the recalcitrant disabled doctor himself, but also to protect his family, his patients, and his whole medical community against the irresponsible behavior which is characteristic of addiction.

Implementation of the Plan by Two Committees

Two specialized and essentially independent committees of the state medical association jointly carry full responsibility for implementing the Georgia Disabled Doctors Plan. One is the Physicians' Consultant Committee (PCC) and the other is the Professional Conduct and Medical Ethics Committee (PCMEC).

Composition and Functions of the PCC

The primary role of the PCC is that of advocate for the disabled doctor (Figure 1).

Membership of the PCC consists of 13 physicians, distributed as widely as possible throughout the state. Each member is either an experienced addictionologist or a recovering alcoholic, in a recommended ratio of five to eight, respectively. Every member of the PCC is prepared to make considerable personal

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sacrifice in terms of time, travel, and energy. Furthermore, each member is well aware of the strong pattern of denial and the persistently relapsing nature which characterizes the addictive diseases.

The functions and responsibilities of the PCC include all the voluntary phases of the plan:

1. To carry out an intense and state-wide program of education about the nature of the addictions and an exposition of the services offered by the PCC
2. To establish identification of disabled doctors
3. To create a trusting relationship with the disabled doctor and his family
4. To motivate the disabled doctor to seek and to complete effective treatment
5. To act as advocate of the disabled doctor, as needed, in his relationship with spouse, family, professional peers, hospital administrator, or other areas of pressure, provided he or she is already in treatment, is preparing to enter treatment, or even if the patient is still in a state of denial
6. To assist the disabled doctor in realistic planning of treatment, rehabilitation, and subsequent reentry into professional activities
7. To provide moral support and practical aid to the disabled doctor and his family from the time of identification through all the ensuing steps of his rehabilitation
8. To be responsive to the requests of the PCMEC.

Functions of the PCMEC as Related to the Disabled Doctor

The primary role of the PCMEC as related to the Disabled Doctor is that of protector of the collective professional integrity of the medical community (Figure 2).

In dealing with the addicted physician, the regular membership of the PCMEC is augmented by two experienced addictionologists, at least one of whom must be a recovering addict. Only the chairperson of the PCC is eligible to serve simultaneously on both the PCMEC and the PCC.

The functions and responsibilities of the PCMEC are to:

1. Refer complaints of addiction and drug abuse to the PCC for validation and for the motivation of voluntary treatment
2. Require the PCC to determine the current status of any disabled doctor who has once begun treatment
3. Make recommendations to the State Board of Medical Examiners regarding any disabled doctor when a majority of the PCMEC membership agrees

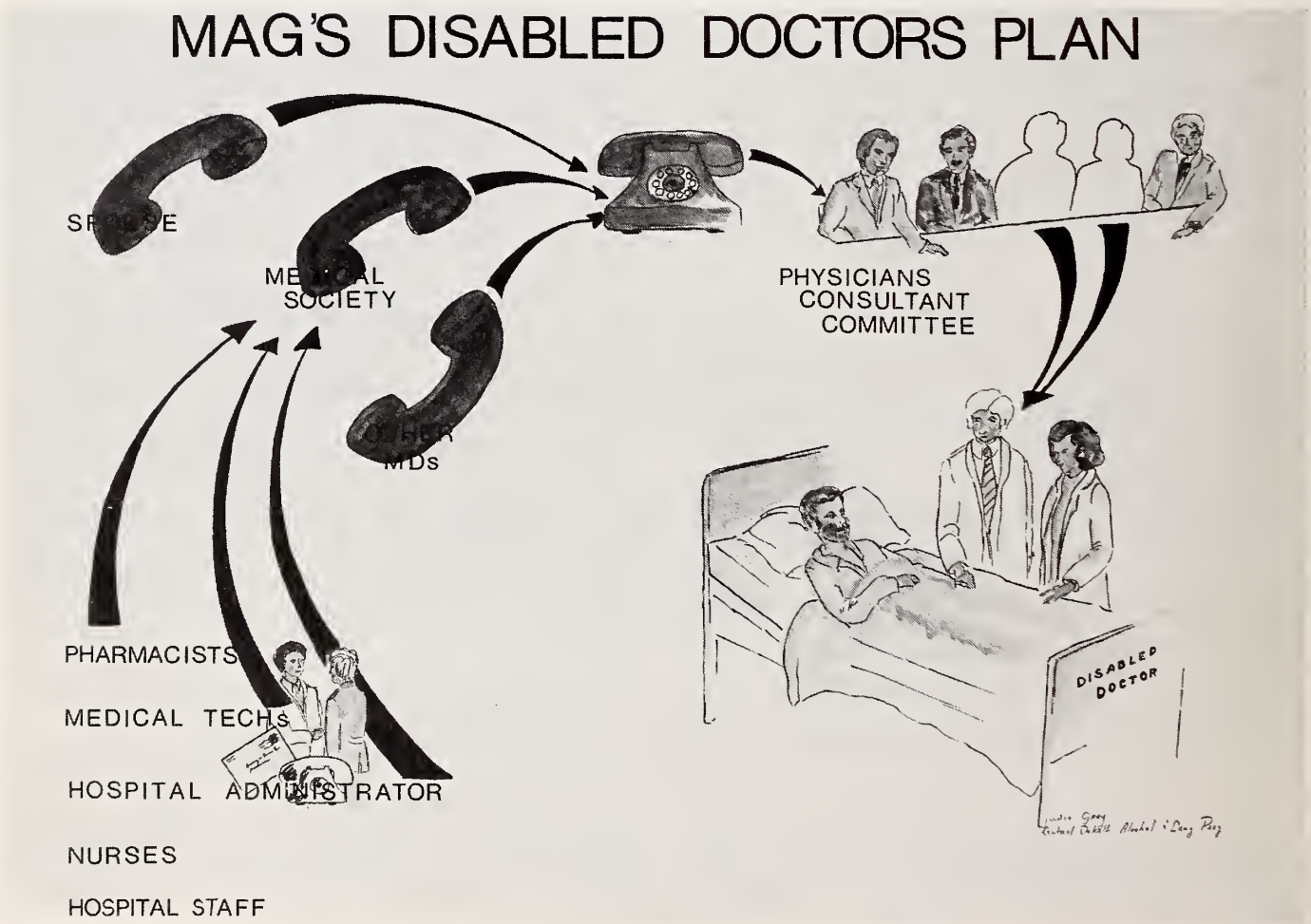


FIGURE 1

that the reasonable efforts of the PCC have failed to produce an acceptable degree of rehabilitation.

Sequential Steps of the Plan

The objectives of the plan are being accomplished in a series of sequential steps:

1. A state-wide exposition of the services made available by the plan
2. Identification of the disabled doctor, with due care to protect his anonymity
3. Validation of the identification
4. Motivation of the disabled doctor to voluntarily seek treatment
5. Aid for the disabled doctor in making realistic plans for treatment and rehabilitation
6. Aid in re-entering professional activities after rehabilitation.

Only if these efforts fail is any coercive or disciplinary action taken by the PCMEC.

Step One: Exposition and Education

It is obvious that the first requirement of this plan is to identify the disabled doctor. The special difficulties of identifying addicts and drug abusers among the medical profession are discussed in a separate paper. To overcome these difficulties there is need for considerable education to remove the moral stigma from the addictions and to persuade both the disabled doctor and those closest to him that the addictions are chronic diseases which can be controlled by proper treatment. There is also need to explain the philosophy and services of the PCC to medical societies and medical auxiliaries throughout the State of Georgia.

In this task we already have made considerable progress. Members of the PCC have talked to many local medical societies and medical auxiliaries. Among other items they emphasize that the PCC is composed chiefly of physicians who are themselves recovering addicts, and hence poignantly familiar with all aspects of the problem; that the members of the PCC steadfastly maintain a non-punitive, non-judgmental attitude; that their primary role is that of aide and advocate for the disabled doctor, and that they pledge themselves to make every effort to protect both the dignity and the anonymity of the disabled doctor. These PCC representatives make it clear that addiction is a disease and that the disease can be controlled through proper treatment, with an anticipated success rate up to 75 percent.

Announcements will be made from time to time to recapitulate the functions and name the membership of the PCC, together with telephone numbers



FIGURE 2

and addresses through which these members can be reached.

To make sure that the Disabled Doctors Plan is clearly understood by the related and appropriate support systems, qualified persons other than physicians are prepared to speak to appropriate groups to present further explanations of the Plan. For example, a hospital administrator, who has already begun using the Disabled Doctors Plan for his own medical staff, recently addressed a meeting of state hospital administrators on this subject. An addictionologist who is also a registered nurse has addressed a meeting of the state association of nurses. The executive director of a local medical society, who is also a co-author of this paper, has explained the Plan to a group of his professional peers. Later it is proposed that an addictionologist who is also a clinical pharmacologist will speak on the same subject at a meeting of his professional group.

This crusade of education and exposition is intended not only to explain the workings of Georgia's Disabled Doctors Plan, but also to help destroy the conspiracy of silence which has so long prevailed in the mistaken notion that such silence is a kindness to an afflicted doctor. It is intended to help remove the moral stigma from the disease of addiction, and may even begin to soften the hard shell of denial, the feeling of profound guilt, and the deliberate isolation which so often surrounds the disabled doctor and prevents his seeking help.

Step Two: Identification and Validation

During and after the described educational campaign, as expected, concerned spouses gained the courage to contact the PCC. It is expected that concerned physicians, medical society personnel, and hospital administrators will become more alert to their responsibility in seeking help for a disabled peer. A few disabled doctors will seek help for themselves.

A crisis line, which makes PCC members accessible 24 hours a day, has been established—(404) 894-5857 or, nights and weekends, (404) 292-5829. All calls are handled sympathetically and reassuringly; some have been made anonymously, and these were handled with special care.

Every telephone call and written report is first unobtrusively investigated and its validity is established before any further action is taken, lest disgruntled or malicious individuals use this method in an attempt to harm an innocent physician. Methods of validation include discreet personal contact with the executive director of the appropriate medical society, with the administrator of the local hospital, and/or with medical peers in the community. Local pharmacists are usually aware of irregularities in drug usage among the physicians of their area, but validation through this group is conducted only with the greatest tact and discretion.

After satisfactory validation, a contact team consisting of two representatives of the PCC is selected by the Committee chairman. Sometimes this team is chosen on the basis of geographic remoteness from the disabled doctor under consideration; sometimes for their proximity. This team makes an appointment for an immediate visit with the doctor.

Step Three: Motivating the Disabled Doctor to Enter Treatment

An initial visit to the disabled doctor naturally presents certain difficulties. Often he or she is wary, resentful, hostile, or full of denial. The visiting PCC team finds its own methods of dealing with these difficulties, but in each instance it is imperative to state immediately and convincingly that the visit is made only because of sincere concern about the problems which obviously face the disabled doctor. The visitors convey that they have specialized knowledge of such problems, and that at least one of them has had personal experience with addiction.

The PCC team offers an advocate's services in dealing with the problems presented by the disabled doctor's spouse and family, his local medical society, the Drug Enforcement Administration, the licensing board and whatever other groups are pressuring him. But it is also clearly stated that these services are contingent upon his unconditional acceptance of the PCC recommendations for treatment.

It must also be made clear that the PCC representatives will no longer have power to intervene in behalf of the disabled doctor if his situation develops to a point which requires review and action by the PCMEC. Often there is a need for repeated visits by the PCC team, not only with the patient himself but also with his spouse, his family, and other sources of pressure or concern. These visits serve several purposes. They permit the PCC team to make explanations which are both detailed and repeated; they allow an objective delineation of the situation from the viewpoints of peers who are both sincerely concerned and particularly well informed; they provide information which facilitates realistic planning on the part of both the patient and his family. Simultaneously, these visits give continuing evidence of the moral support and understanding offered by the PCC team.

Step Four: Treatment and Rehabilitation

The respective advantages of the many well-qualified treatment sources available will have been

discussed during the visits of the PCC team to the disabled doctor and his family. Depending on circumstances and individual attitude, the patient is thus prepared to choose a treatment center near his home or outside Georgia, as he prefers.

At this point, each disabled doctor in the Georgia plan signs a one-year "contract" to complete the treatment plan agreed upon and approved by the PCC. Such a document is not so much legal as motivational in nature. Each "contract" is carefully constructed to meet the special needs of the individual physician.

Assistance is offered in planning the interim care of the practice, of business affairs, and of the dependent family. The PCC representatives will remain in friendly contact with the disabled doctor throughout the period of his treatment and rehabilitation, and will act as liaison with his home affairs if so requested.

As treatment nears a satisfactory conclusion, the PCC representatives begin helping the doctor to make realistic plans for the future.

Step Five: Re-Entry into Professional Activity

The PCC representatives offer sponsorship as needed when the disabled doctor is ready to resume professional activity. The entire membership of PCC is on call to offer suggestions, advise of professional openings, and provide whatever assistance can be given. The PCC team counsels the family as needed during this trying period, and actively encourages both doctor and family to make new social contacts, particularly with AA.

In the majority of cases the procedures here outlined as sequential steps have served to gradually return the disabled doctor to a useful and responsible place in the professional community. Obviously some individuals require from the PCC more time, patience, and effort than others. Much depends on the attitudes that have been inculcated in their support systems—in spouse, family, medical society, professional peers, and others.

Alternative Action When Attempts of PCC Fail

Realistically, we were prepared for failures in our efforts to persuade a disabled doctor into treatment and satisfactory rehabilitation. It then becomes necessary to exercise coercive powers in an effort to protect the patients, the integrity of the entire medical community, the affected family, and the disabled doctor himself from the irresponsible behavior generated by uncontrolled addiction. This is the function of the PCMEC.

If a disabled doctor consistently refuses to enter treatment, or attempts to resume practice without successfully completing treatment, his or her behavior almost invariably is noted and reported to the PCMEC. In reality, this has happened only once among the 17 disabled doctors who had entered treatment during 1975-1976.

When a complaint first reaches the PCMEC, a request goes to the PCC for immediate investigation and validation. This can result in the activation of either an original or a repeated attempt on the part of the PCC to secure the disabled doctor's cooperation and voluntary treatment. If it is a repeated attempt, the PCC membership must decide whether to send back the original team or to appoint a new team of PCC representatives. The process already described is then begun, and continued for as long a time as the team feels there is any chance of success in their efforts to persuade the disabled doctor into voluntary treatment, before the case is ultimately presented to the PCMEC for review and possible action. On a second complaint to the PCMEC, if validated by the PCC, the entire membership of the PCMEC must meet to decide by majority vote, on the most appropriate course of action.

First, it must be determined that any prior complaints have been investigated, validated, and followed up by the PCC. Each followup entails the warning, already issued, that the PCC is powerless to intervene if the case comes to review by the PCMEC.

Second, the PCMEC must make sure that voluntary treatment has been either refused or abandoned by the doctor in question.

Third, the PCMEC must request and receive from the PCC a brief written report as to the current status of the disabled doctor with respect to his continued use of drugs, attempts to practice, and the progress he has made in treatment, or his plans for future treatment.

Acting on the basis of this information, the PCMEC decides, by majority vote, whether or not to recommend to the State Board of Medical Examiners the suspension of license to practice until treatment and rehabilitation have been completed to the committee's satisfaction.

The PCMEC legally has no power beyond that of recommendation, but as a matter of practice it is expected that the State Board of Medical Examiners will follow the recommendation of the PCMEC.

Involuntary monitored treatment may be imposed only through the Office of the State Attorney General, and in view of our experience is now regarded as a remote possibility, to be resorted to only in the event of flagrant and repeated professional misbehavior. If imposed, the disabled doctor retains the right to seek legal interruption of monitored treatment at stated intervals, through petition

to the Office of the State's Attorney General.

Summary

The Disabled Doctors Plan, working chiefly through the PCC, first identifies the disabled doctor, then persuades him or her to seek voluntary treatment for his or her illness, while offering both the doctor and his, or her, family every possible support and assistance. Finally, the plan provides for the sponsored re-entry of the rehabilitated doctor into full professional activity.

Emphasis is on a voluntary, compassionate and non-punitive plan for the treatment of the disabled doctor. However, it is also necessary to provide protection from the irresponsible behavior of the addict who repeatedly refuses either to begin or to complete treatment. For this purpose, PCMEC is empowered to recommend, after suitable investigation and on majority vote, that the State Board of Medical Examiner take appropriate disciplinary measures.

As a final and seldom-used resort, it will be possible to legally impose monitored treatment through recourse to the Office of the State's Attorney General. ■

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The easy availability of drugs to the highly pressured physician makes addiction nearly an "occupational hazard."

Some Dynamics of Addiction Among Physicians

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THE PRIME OCCUPATIONAL hazard in the practice of medicine is the disease of addiction to alcohol and to other drugs.

This hazard, currently widespread among our whole population, is exceptionally great for the physician for a number of reasons: Many times the doctor finds it necessary to prescribe drugs to patients who have exactly the same symptoms which he himself experiences; the "invincibility ethos" so carefully developed in medical school makes it difficult for the physician to admit a personal problem; the stress of professional responsibility and obligation is ever present, ever increasing, while time for relaxation becomes an increasingly rare commodity; and a wide variety of mood-changing drugs is always instantly available, with no questions asked. It becomes very tempting, very easy, to turn to a mood-changing drug—alcohol or whatever—when time is short and pressures are many. And thus insidiously an addiction develops. Whether the addiction be to alcohol, to some other drug, or to several drugs interchangeably, circumstances have been created which are more than likely to produce another disabled doctor, one who is no longer in full command of his or her faculties at all times, one who is potentially a source of harm rather than good.

To meet this growing problem, the Medical Association of Georgia recently has instituted a Disabled Doctors Plan, explained elsewhere in this issue. This plan limits itself to the physician whose work is impaired by the disease of alcoholism or other drug addiction. Although the program is still very young, the volume of physicians seen to date, plus the authors' prior experience in dealing with disabled doctors, makes it possible to identify and elucidate some of the dynamics of addiction which exert considerable force among this specialized group of patients.

The Georgia program for disabled doctors consists of four major phases: identification, motivation, treatment, and re-entry into the world of medical service. We believe that a knowledge of some of the dynamics underlying each of these phases is essential to the development of an effective program of treatment and rehabilitation for the disabled doctor. Therefore, we will consider each phase in turn.

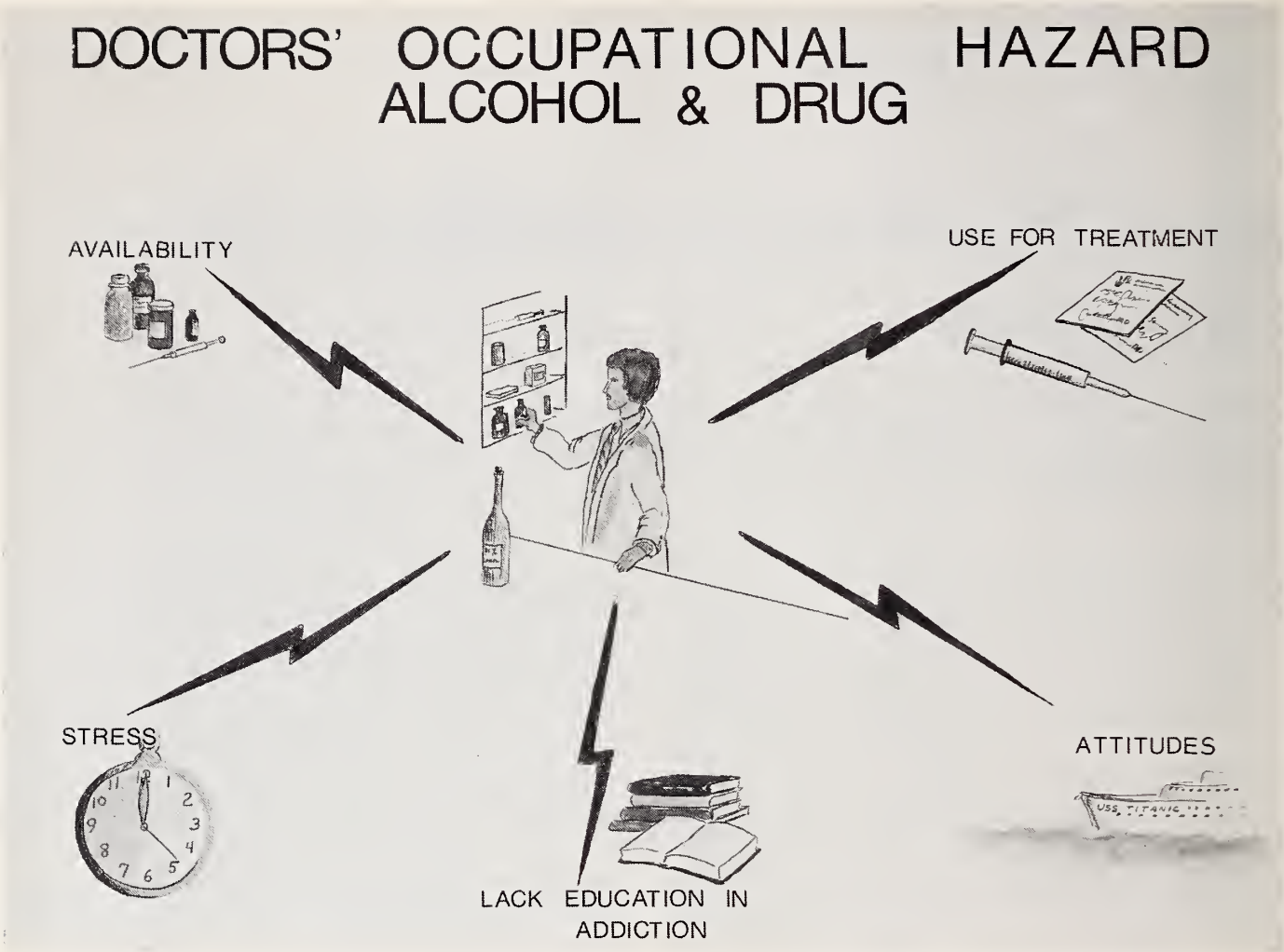
Identification

Identification of the physician who is disabled because of alcoholism or some other drug addiction is obviously the first step in any plan of help. But this seemingly simple procedure is made exceedingly difficult because of two major factors which may be peculiar to the medical profession.

First, the afflicted physician is literally unable to aggressively seek treatment or even counselling. The reasons are varied in their details, but some strong basic patterns are apparent in the fabric of his or her reluctance: As a member of a traditionally honored, elite, and care-taking group he or she has been in the habit of exhibiting compassion, remaining calm in a sea of turmoil, and quickly making life-or-death decisions which are unquestioningly received by others. The disabled doctor does not easily accept a reversal of roles.

The literature of addiction reveals that it is most common for a patient whose basic disease is dependency on alcohol or other drugs to first consult his family physician in search of help. But to whom does the sick physician turn? Both observation and experience tell him that if he consults one of his professional colleagues his true diagnosis will be either ignored or over-emphasized, and in either instance

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his immediate physical complaints will receive little effective attention. In any event, the average disabled doctor is loathe to consult a professional peer for any condition less blameless and obvious than a compound fracture—certainly not for anything so vague as insomnia, constant anxiety, frequent tremulousness, or the urgent need for a morning drink.

Second, the disabled doctor has no inviolate refuge where he or she can feel sure of receiving care and understanding without either censure or painful exploration of personal history. The Catholic Church has found that their disabled priests and nuns respond far better to treatment that is provided for them in a setting consistent with their accustomed way of life, among patients of their own kind. Some sects of the Protestant clergy have come to the same conclusion. But as yet there is no place of treatment, no group of therapists dedicated solely to the treatment and rehabilitation of the disabled doctor.

Third, the diagnosis of the disabled doctor is usually delayed, and sometimes prevented, by a conspiracy of silence which surrounds him or her in a mistaken effort at protection. This conspiracy extends from the immediate family to office personnel, to hospital staff, and even to professional peers. It is fed by a variety of motives and emotions: anger, fear, guilt, hopelessness, shame, and perhaps a feeling of "There but for the grace of God go I!" Such a conspiracy may be well meant, but it is inevitably destructive and should be abolished. It puts at unnecessary risk not only the future of the disabled doctor himself but also the welfare of his family, his friends, his professional colleagues, and even the very lives of his patients.

The earlier the disabled doctor's disease is recognized and treated, the better his chances of again becoming a useful member of his profession.

Motivating the Disabled Doctor to Enter Treatment

Once identified, it may be an even more difficult task to motivate the disabled doctor to enter treatment. Massive denial is characteristic of the disease of addiction and seems especially strong among members of the medical profession. Among other causes, their strong denial seems attributable to their ignorance of or their unwillingness to accept the validity of the disease concept of addiction. Further-

more, the doctor constantly sees friends and professional colleagues indulging in alcohol or other drugs with seeming impunity; and he or she is extremely conscious of the "cloak of invincibility" which was so carefully woven around the person of the undergraduate student. The too common attitude among successful physicians is, "It can't happen to me! Other people may fall into the trap of addiction, but I am smart enough to avoid it!"

Unfortunately, the victim of addiction learns too late that he or she grossly overestimated his or her resistance. Yet the pattern of denial may persist, against all evidence and reason.

Denial may take various forms in addition to a refusal to acknowledge the fact of addiction. It may be manifested as pronounced hostility toward all therapists, or a multitude of hypochondrical symptoms, or refusal to communicate. The patient in denial may persist in physical as well as verbal isolation. All these symptoms must be recognized as forms of denial before they can be successfully countered.

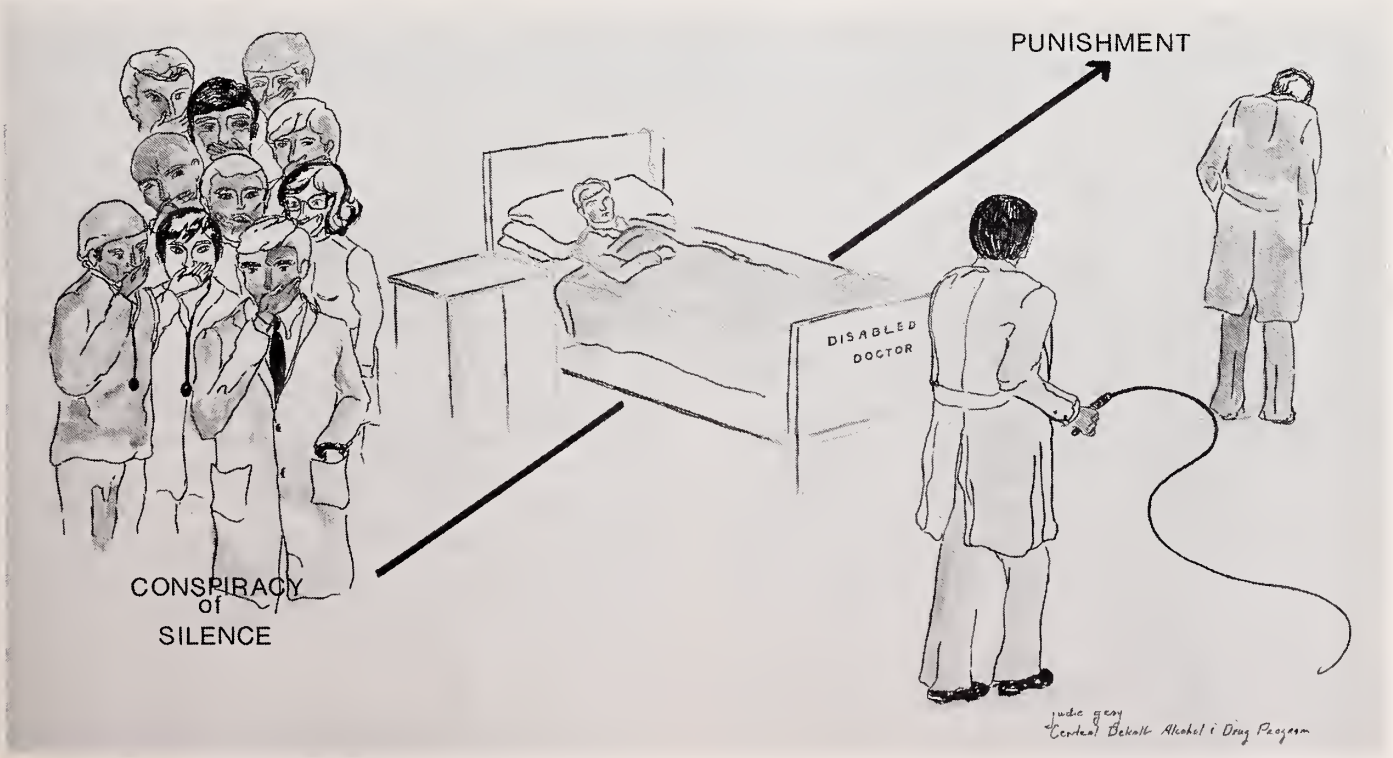
Either true ignorance or, more likely, a refusal to wholly accept the disease concept of addiction often prevents a disabled doctor from experiencing true motivation toward treatment. If he does not fully believe that addiction is a condition that is both treatable and free of moral stigma, then he is easy prey to self-accusation, feelings of guilt, anger, hopelessness, and self-protective denial, all of which push him further and further away from therapy.

It is remarkable to see the change which occurs when the disease concept is convincingly presented and ultimately grasped by the disabled doctor. He or she then becomes anxious to begin treatment, for coping with a disease entity is a challenge which medical training has fully prepared the doctor to accept and presents a task which he or she can fully understand and in which there is every reason to hope for success. Though the doctor may have given lip service for years to the axiom that addiction is a disease, his or her first complete, meaningful, and whole-hearted acceptance of that concept marks an important step towards recovery.

Treatment of the Disabled Doctor

It has been customary to lump together addicts from all walks of life to receive therapy as a single unit. Our Disabled Doctors Plan as practiced in Georgia has demonstrated that for physicians, at least, the individualization of treatment is not only useful but in many instances may be necessary. Our present mini-track record of steady progress in the treatment of 17 disabled doctors, primarily by the individual approach, speaks well for this method.

All disabled doctors who enter our program are requested to sign a contract with the Physicians' Consultant Committee (PCC). This contract specifies the treatment components chosen by the representatives of the Committee, after due consideration, as being best suited to this individual. It is recognized that such a contract is not legally binding, but it does represent a statement of intent on the part of both the doctor and the Committee, and is considered to



be morally binding on both parties. The contract expresses an obligation on the part of the disabled doctor to remain in treatment for the length of time recommended by the PCC, a period of time which is to be determined by his own response. On the other hand the contract obliges the PCC to assume certain responsibilities for the care and welfare of the patient, including the circumstances of his re-entry into medical work. The contract is reviewed and co-signed by at least one other member of the executive branch of the PCC.

Sometimes individual needs and circumstances make it feasible to first send the patient to some recommended residential treatment center, such as Chitchat or Willingway, for a 28 day course of intensive treatment, but this is comparatively rare.

When daily treatment at DeKalb is prescribed, the disabled doctor participates as a patient during the first 30 to 60 days. Next he works for a period of several weeks as an intern in the DeKalb Addiction Program. He then completes the year as a staff member.

A large element of the treatment program provides for self-help which is subject to constant peer review. Many activities are prescribed on an individual basis to meet specific individual needs, but meetings for the purpose of both education and therapy are held both day and evening. An individual prescription in part might vary, for example, from two nightly meetings per week for a specified length of time to an assignment of daily meetings for a full year; in either case the duration of the prescription would be subject to frequent review.

In the self-help sessions which are under peer-group supervision, emphasis is placed on non-chemical coping procedures as a means of meeting life's problems. This is a comparatively new approach to treatment, but there are promising indications of its usefulness, particularly in the treatment of the disabled doctor.

Confrontation often becomes necessary in the treatment of the disabled doctor. Occasionally coercion is required to enforce treatment recommendations. When the denial pattern persists unduly and thus persistently blocks rehabilitation, or when the patient continues to place irrational emphasis on such things as money, mistaken professional obligation, or fear of either social or professional reprisals, the only effective tool with which to overcome such roadblocks is by the use of coercion.

Under the Disabled Doctors Plan as used in Georgia, confrontation is carried out by a team of physicians representing the Physicians' Consultant Committee, one member of which must be a recovering addict. Usually the disabled doctor can more easily establish rapport with a physician who is also a recovering addict than with a person who is qualified chiefly as a practitioner of medicine or chiefly as one who has personally experienced the disease of addiction.

If coercion becomes necessary, the case is referred to the Committee concerned with Professional Conduct and Ethics, which maintains close liaison with the Board of Medical Examiners. Thus as a last alternative to entering treatment, the disabled doctor is faced with the threat of possible limitation, suspension, or even revocation of his license to practice medicine. This represents perhaps the greatest fear of his life and endangers all that he holds most dear. It is a great and powerful weapon. Experience to date indicates that it will but rarely need to be invoked.

Re-Entry

As used in the Georgia Disabled Doctors Program, the term "re-entry" describes the period of time between successful completion of a period of treatment and rehabilitation and the time when the formerly disabled doctor can resume the useful, independent practice of his profession.

This period of time is frequently beset by guilt, shame, fear, anger, or other destructive emotions, and may all too easily be accompanied by loneliness and a feeling of isolation.

Nothing combats these negative feelings more successfully than the certain knowledge that a trusted friend (therapist) has also traveled this same path, and now stands ready to offer understanding and reassurance as needed. This function may be well served by either an AA sponsor or by a member of the PCC team, and sometimes both are needed. If left neglected and unsupported, this is the time when the recovering physician is highly susceptible to another acute attack of his disease. Loneliness and a sense of isolation breed recidivism. This danger must be fully recognized, and the recovering physician must continue to receive emotional support over a varying period of time. It is a function of the disabled doctor's coordinator to make sure that family, medical peers, hospital staff, and members of the local medical society are fully aware of the disease concept of addiction and are as well prepared to receive the recovering doctor back in their midst as if he were returning from hospitalization because of any other long and life-threatening illness.

Conclusion

Since the disease of addiction is the greatest occu-

pational health hazard faced today by members of the medical profession, it is urgent for each state to devise and implement its own plan for the treatment and rehabilitation of doctors who are disabled by alcoholism or other drug addiction.

An understanding of the dynamics of addiction, particularly as they apply to the special problems of the addicted physician, is a prerequisite to the formulation of a successful plan of treatment and rehabilitation. The greatest success can be achieved only when details of treatment are individualized for each patient.

The period of re-entry into active social and professional activity can be extremely hazardous. Therefore, it is important that the therapeutic team of PCC representatives concerned with the rehabilitation of any given individual remain closely associated with, or at least easily available to, the disabled doctor until he or she seems safely re-established. Even then the recovered physician must always feel free to call upon the team for consultation, emotional catharsis, and moral support when necessary.

The Georgia Plan for the Disabled Doctors has demonstrated that alcoholism and other drug addictions are diseases which can be successfully treated when the dynamics of these disorders are recognized and taken into account. ■

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NATIONAL SPEAKERS SCHEDULED FOR ATLANTA PATHOLOGISTS MEETING IN MAY

A one and a half day Spring Seminar has been scheduled for May 1-2, 1976 at the Omni International Hotel and is sponsored by the Atlanta Society of Pathologists, Georgia Association of Pathologists and College of American Pathologists.

The Saturday portion is titled "The Neoplastic Lymphoproferative Disorders" and includes guest speakers James J. Butler, M.D. of the University of Texas Cancer Center; Robert D. Collins, M.D. of Vanderbilt; John Bennett, M.D. of the University of Rochester School of Medicine; and Philip H. Lieberman, M.D. of Memorial Sloan-Kettering Cancer Center.

The Sunday morning session "Pathology of Lymphoid Lesions," will feature Dr. Lieberman.

The program is supported in part by the American Cancer Society, Georgia Division and has been accredited by the AMA Council on Medical Education and the Medical Association of Georgia.

Slide sets and case histories are available for the Seminar on Pathology of Lymphoid Lesions, at a cost of $25. For information contact: Robert E. DeLashmutt, M.D., Pathology Department, Georgia Baptist Hospital, 300 Boulevard, N.E., Atlanta, Ga. 30312.

APRIL SYMPOSIUM EXAMINES THE RIGHTS OF THE BATTERED CHILD AND THE JUVENILE DELINQUENT

A meeting devoted to the Rights of Children, focusing on the juvenile justice system, has been scheduled as the 4th Annual Interdisciplinary Symposium in Law and Behavioral Sciences. The meeting will be held from 8:30 a.m. to 4 p.m. April 23, 1976 in the Auditorium of the Georgia Mental Health Institute, 1256 Briarcliff Road in Decatur.

Principal speakers include Milton Luger, head of the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice; Judge Jack Gunter, Superior Court judge and juvenile judge of the Georgia Mountain Judicial Circuit; Ellen Leitzer, J.D., staff attorney for the American Civil Liberties Foundation of Georgia and director of the ACLU Child Advocacy Project; and Jule Sugerman, chief administrative officer for the City of Atlanta. Mr. Sugerman was the creator of the national Head Start Program and the Federal Office of Child Development.

The program is sponsored by the Forensic Psychiatry Service of Grady Memorial Hospital, the Department of Psychiatry of Emory University School of Medicine and the Emory University School of Law.

The morning program will include a discussion of the rights of children and the problems of juvenile delinquents, followed by workshops on: a new family court concept; psychiatric evaluations for court use, admission and confinement of minors to mental health institutions; the battered child; the future of probation; the legal approach to children's rights; the right to treatment for delinquents; the exception offender; alternatives to institutionalization; and facilities for juvenile institutionalization and deinstitutionalization in Georgia.

Topics for the afternoon include: the bench and the rights of juvenile delinquents; the right to treatment for status offenders; and children and social change.

For information and registration call (404) 377-2411, ext. 7901; or write Symposium—Rights of Children, Room 328, Emory University Law School, Atlanta, Ga. 30322. The admission fee is $3.

Medical societies nationwide now are recognizing their responsibility for creating programs to identify and treat the alcoholic physician.

The Physician With Alcoholism

FRANK A. SEIXAS, M.D., *New York**

AMONG THE HAZARDS leading to physician disablement, alcoholism has been the most ignored and has probably affected the most individuals. Inattention to the problem is documented by the fact that from 1962-1973, out of 3,525 physician's licenses revoked, only 33 cases of revocation were attributed to alcoholism.[1] During the years 1971-1974, only three physician's licenses were revoked with the citation of alcoholism,[2] and in 1974 the reason of alcoholism was not given for even one physician's license revocation—and there are 320,000 licensed physicians in the United States.[3]

These statistics mirror the situation found in court procedures involving driving under the influence of liquor (DUIL). In New York City some years ago, when a DUIL first offense was a misdemeanor, and the second offense a felony, there were 3,400 convictions for DUIL first offense and only nine for second offense.[4] It was obvious that alcoholic behavior was then thought serious only up to the point that serious consequences would be entailed for the alcoholic. Then plea-bargaining became the rule. The institution of court-related treatment for alcoholism in the traffic courts has resulted in huge increases of convictions for DUIL, with a concurrent decrease in highway fatalities.

Fatal to Oneself and Others

We are now on the threshold of a new era of conceptualization of alcoholism. We have begun to realize that if alcoholism is not stopped in the individual, it will be fatal. And for a physician, even more so than for the automobile driver, it can also be fatal to others. It has become possible for a few of us to look at this objectively because we now recognize that many can recover from alcoholism, and it is apparent that alcoholism among physicians cannot be mysteriously absent while at the same time afflicting 5.6 per cent of the rest of the labor force.[5]

Last year, spurred on by some pioneer efforts in the field, as well as by the malpractice crisis, the AMA held a conference in San Francisco to study and discuss means of dealing with a problem within their ranks—that of the disabled physician.[2] At that time, the estimate was presented that seven or eight per cent of our physicians are engaged in excessive drinking. This would put approximately 10,000 individuals in direct and present need of help.

There are a number of impediments to meeting that need. First is the denial process so common in alcoholism, which not only makes the physician naturally cautious about revealing his need for alcohol, but actually prevents him from recognizing the connection between his drinking and other related events. Second and most crucial is the "conspiracy of silence" about alcoholism, which is nowhere so strongly entrenched as in the medical fraternity. The reluctance of most doctors to report incompetent work has been cited as "the greatest obstacle to better regulation of the medical profession."[2]

Legal Responsibility of Associates

This gang spirit and reluctance to "squeal on a buddy" is being countered in many ways. Recognition is becoming more widespread that alcoholism is an involuntary and pathological condition for the individual so afflicted, and that refusing to intercede is tantamount to "killing with kindness."[5] Humane ways are being invented to initiate the confrontation. And malpractice issues have made the medical profession recognize that every brother who commits malpractice thereby contributes to the skyrocketing insurance costs which are beginning to make the private practice of medicine almost impossible. California and Florida have now ruled that in instances where a doctor disabled by alcoholism has not been prevented from practicing, other involved physicians as well as the hospital are equally liable in the case of a malpractice suit.[6] This puts a legal responsibility on the associates of an alcoholic physician—one which can be used in favor of his health. Fortunate-

* Medical director of the National Council on Alcoholism, 2 Park Ave., New York, N.Y. 10016.

ly, great strides have been made throughout the United States in providing treatment units which are effective, confidential and in pleasant surroundings. Thus, the lack of treatment facilities can no longer be considered a possible impediment to recovery.

Treating the Alcoholic Physician

In order to attack the problem of the alcoholic physician, there is needed a stated policy coming from the top—in this case the medical society or the medical institution—incorporating in its principles that:

1. Alcoholism will be treated as a disease,
2. If treatment is not taken, any resulting inefficiency will be subject to appropriate action,
3. Decline of performance would be a case-finding method,
4. Any resulting investigation would be conducted by fellow professionals.

A helpful guide to the diagnosis of alcoholism is the document the "NCA Criteria for the Diagnosis of Alcoholism."[7] Since these criteria will be found to apply to physicians as well as others, this can be used with telling effect in a confrontation. Doctors often accept help if they are shown that because of incompetent work they are in danger of hurting, or perhaps even in danger of contributing to the death of a patient.

Finally, the biggest stick that can be wielded in the attack on the disease of alcoholism among physicians is the denial of practice—first through loss of hospital privileges, then through loss of license. But of course each step of the way should be coupled with the offer of effective help.

Since the AMA meeting in San Francisco and surrounding it in time, different plans have been adopted by several of the state medical societies. In New York a committee, activated by two colleagues, will visit a suspected case to inform him about the possible existence of a problem and offer help—making no record or identification. In this situation, the diagnostic effort and any contingent therapeutic guidance are separated from the possible punitive or policing action, on ethical grounds.[8] In Georgia, identification, treatment and punishment are coordinated in one group which, it is felt, exercises more direct control and a greater possibility of effective treatment.[9] Both systems seem to be working although it is still too early for their full effectiveness to be documented. One thing that the institution of these plans has thrown into bold relief is the fact that many more cases of alcoholism amongst the medical profession have come to light—many more than the previous statistics on license suspension might indicate.

The *Journal of the Medical Association of Georgia* is to be congratulated on making this entire issue a discussion of the question of the alcoholic physician and a solution to the problem. Douglas Talbott, M.D., who has chaired the Committee, is also to be congratulated for his forthright and courageous work which has already saved the lives and careers of several of our colleagues.

Assisting Others Toward Recovery

The National Council on Alcoholism and its medical component, the American Medical Society on Alcoholism, have a great stake in seeing that all population groups are being afforded an entry into treatment for alcoholism. But this is particularly true for the alcoholic physician who, by the knowledge gained during his illness and recovery, can become a major force in diagnosing and assisting others to their own recovery. More than that, he can assist in educating other physicians and medical students toward the same ends.

The 900 members of the American Medical Society on Alcoholism, by their demonstrated interest and experience, can be of great help to medical societies in setting up and manning programs of identification and treatment. Because of the current importance of the subject, a special workshop on "The Alcoholic Physician" will be held at the NCA/AMSA annual medical-scientific meeting, May 6-8, 1976, at the Shoreham Americana, Washington, D.C.

Another organization, the International Doctors in Alcoholics Anonymous, comprised of physicians who are recovering from alcoholism, stands ready with warmth and friendship to welcome colleagues who are essaying the way back.

For the Georgia physician, perusal of this volume will be important for its timeliness and effectiveness in bringing a new therapeutic tool to medical practice, one that enables us to fulfill the wise words:

"Physician, heal thyself." ■

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Addiction is explained as a chronic disease that is never "cured," but is susceptible to control, with an etiology that probably is physiological.

Concept of Addiction

KENNETH E. SHOEMAKER, M.D., *Decatur**

In the context of this paper, addiction may be defined as psychological and physiological dependence on one or more drugs.

Addiction is often thought of only in relation to the "hard" drugs such as heroin, cocaine, or morphine. However, it is not only possible but alarmingly common to become both psychologically and physiologically dependent on a wide variety of "soft" drugs such as various stimulants, tranquilizers, sedatives, anesthetics, and analgesics. Alcohol is by far the drug most widely used in this country at present, and alcoholism is the most prevalent addiction.

Alcoholism is the primary focus of this paper, but most of what is written here about alcoholism applies just as well to the other "soft" drug addictions. Paraphrasing a popular writer of the twenties, "An addiction is an addiction is an addiction," whatever the drug involved.

It is the purpose of this paper to briefly review the history of alcoholism, to elucidate our philosophy of alcoholism as a disease and the type of treatment necessary to control it, to describe the diagnostic model used in the Alcohol and Drug Program in DeKalb County, and to mention our methods of treatment.

Historical Background

In history we can find myriad allusions to alcohol and to intoxication. There are more than 270 references to alcohol in the Bible alone. The substance has been with us for thousands of years, and the disease of alcoholism is equally ancient.

In every age, in every civilization, in every land there have been those unfortunates who were neither physiologically able to handle alcohol nor psychologically able to leave it alone. Doubtless the drug will continue to be made and used as long as mankind survives. We can only hope that increasing knowledge and wide-spread education will enable those who need to abstain to recognize and abide by that need before irremediable damage is done.

It is one of our present weaknesses that comparatively little valid information about the addictions, including alcoholism, exists. For example, it was not until 1953 that withdrawal was identified, by Maurice Victor, as a clinical entity. While our knowledge of many other diseases has taken phenomenal strides during the past century, alcoholism has happened to lag behind. Only in recent years have we begun, as a nation, to shift from purely punitive measures to treatment.

Though the decriminalization of public intoxication, begun during the past few years, is an important step forward, the concept itself is not new; it merely has new support. As early as 1790, Dr. Benjamin Rush, a great humanitarian, advocated decriminalization. He pled that alcoholics be freed from behind the locked doors where hundreds of them languished, and that they be given medical care. In his challenging book entitled "An Enquiry into the Effects of Ardent Spirits Upon the Human Body and Mind," published in 1814, Dr. Rush said:

> "Let us not then pass by the prostrate sufferer from strong drink, but administer to him the same relief we would afford to a fellow creature in a similar state from an accidental and innocent cause."[6]

To briefly review the highlights of the history of alcoholism and the attitudes toward it during the past 125 years, we note first the rise of the Washington Movement in the mid 1800's. This group utilized community services, organized units comparable to our present-day halfway houses, and treated alcoholics with the respect due any other human being.

Almost simultaneously the Temperance Movement began to develop, exhibiting the moderate tendencies which its name implied and thus augmenting the Washington Movement. Unfortunately, a radical element, which advocated total abstinence for everyone, developed within the Temperance Movement. In 1874 this militant group gave rise to the Women's Christian Temperance Union, best remembered for its aggressive activities promoting total abstinence. In the polarization of views, the original and literal

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meaning of "temperance" was totally obscured. The result was the enactment of nation-wide Prohibition, which existed from 1919-1933.

During this period, what happened to the alcoholic?

He was punished. Sometimes he was sent to jail, where he might suffer the symptoms of withdrawal totally without the comfort of medical aid. Sometimes he was sent to an asylum, where he was indiscriminately housed with the criminally insane, and where his sole treatment, if it could be called that, was "protective detention."

In 1934 came the first flicker of enduring hope for the rehabilitation of the alcoholic—the birth of Alcoholics Anonymous (AA).

This self-help group has expanded to the present world-wide network of AA units, and has provided a most effective system of rehabilitation.

In the beginning, AA grew slowly, handicapped by adverse public opinion and the resultant need for protective anonymity. It was not until the other-drug epidemic of the sixties that public attention was again focused on alcoholism, this time in a more constructive manner. As a result, the National Institute of Alcoholism and Alcohol Abuse (NIAAA) was formed. In 1970, Federal funds became available for the treatment and rehabilitation of alcoholics.

One major difficulty persisted: few facts were known about the biochemical and physiological effects of ethyl alcohol on the human body.

Came a flood of books and articles on alcoholism. But most of the writing consisted, primarily, of varied presentations of individual bias rather than conclusions based on accurate data obtained from study of the alcoholic himself. So our ignorance of the precise nature of alcoholism continued, almost unabated.

Alcoholism as a Disease

We maintain that alcoholism is a disease, an addiction phenomenon. Addiction to any drug is a disease. Many drugs are cross-addicting, and are used either as supplements to, or as substitutes for, alcohol.

Psychiatric disorders may exist in an alcoholic, but, except in a small minority of cases, such disorders are independent of the primary disease, which is alcoholism. As an analogy, a patient may have both pneumonia and acute appendicitis, though the two conditions are not related except coincidentally. The attending physician must first treat the emergency. The same holds true for alcoholism and a coexisting psychiatric disorder. Treat the alcoholism first!

To successfully treat alcoholism one must first teach people, both alcoholics and their families, about the realities of addiction: That it is a chronic disease, free of moral stigmata; that it is never "cured" but is susceptible to control; that its etiology, though so far undetermined, is probably physiological.

The traditional treatment model of the psychotherapist in dealing with alcoholism has been, for all practical purposes, a dismal failure, because this model has emphasized etiology and has made exploration of the individual's reasons for drinking a prerequisite to treatment. Such exploration requires considerable time. Quite often the patient turns away from his therapist in disappointment and frustration before any benefit has been derived.

As a psychiatrist, I might explore an alcoholic patient's history and medicate him or her in traditional psychotherapeutic manner indefinitely. But if I would actually improve his condition I must also teach that patient to understand the nature of his or her addiction and to accept its realities.

Why do people drink alcohol? Both alcoholics and non-alcoholics use alcohol for the same two major reasons: because it gives relief (from anxiety, tension, and fatigue), and because it gives pleasure (heightens self-esteem, increases self-confidence, removes inhibitions, facilitates social intercourse).

But why does any specific alcoholic *continue* to drink after he has demonstrated, time after time, that, out of the eight or ten who can indulge in alcoholic beverages with seeming impunity, he is the one person who suffers increasingly ill effects?

Is it essential that we know that answer before we even begin to treat him, or her?

If we had handled the cancer problem in the same manner, many cancer patients who are still leading useful lives would have died, untreated, while their physicians searched for the etiology of their disease. Fortunately, clinical physicians have been treating such patients with the best means at their disposal, often with considerable success, while laboratory workers continue the search for cause. When the cause or causes of malignancies are finally found, it will simply mean that treatment will become more direct, more certain in its effect, and probably more brief. Of even greater importance, knowledge of the exact etiology should lead to more effective modes of prevention. So it should be with alcoholism.

Already some progress has been made. We have learned that in alcoholism many complex changes occur in the body, some of which have now been identified and documented.

The clinician's greatest potential contributions to research are careful observation of the patient and the maintenance of meticulous records, particularly of his response to treatment.

Diagnosis of Alcoholism

What are the clinical features of alcoholism? How can we recognize the disease?

All of the following symptoms are generally pre-

sented in fully developed alcoholism. The presence of a single symptom, or even a cluster of three or four, does not justify a positive diagnosis.

1. *There is a history of non-addictive drinking.* The time required for the development of addiction to alcohol seems to average between 15 and 18 years, with exceptions at both extremes. This time-span is generally much greater than that required for "hard" drugs, but lesser than for most of the other "soft" drugs.

2. *The patient shows increased or unusual tolerance to alcohol.* The true alcoholic usually has a history of being able to drink more than his companions. He may boast of his "wooden leg," or he may be honestly unaware of the extent of his intake of alcohol. The vehicle used is as important as the quantity of beverage, for people tend to minimize the effect of some drinks, such as beer; it is well to remember that two six-packs of 12-ounce containers of beer contain as much ethyl alcohol as one pint of bourbon. It is also necessary to learn if the patient is potentiating the effect of alcohol by taking additional drugs.

3. *There is a gradual loss of control.* This symptom begins to appear early in the development of the addiction. It is manifested by blackouts (amnesia) of short duration, by unsuccessful attempts to limit the amount of alcohol ingested or the time of its consumption, by the rise of feelings of guilt, remorse, anxiety, and depression, and by the emergence of the defense mechanisms of denial, projection, and rationalization.

4. *Withdrawal symptoms appear.* This, too begins rather early in the development of the addiction. It may first manifest itself as morning tremor which must be subdued by a morning drink before the drinker is able to go to work; or insomnia may occur and require a drink in the middle of the night before the alcoholic can return to sleep.

There are four progressive stages of withdrawal, though the symptoms may be cumulative. Stage I is manifested by "the shakes," insomnia, elevated blood pressure, elevated pulse, anorexia, and diaphoresis. Stage II is manifested by hallucinations of any of the senses, but more commonly auditory and/or visual. Stage III is characterized by convulsive seizures. Stage IV is commonly referred to as "DT's," or delirium tremens, and if the patient does not receive medical attention this condition is potentially fatal.

5. *The alcoholic resorts to compensatory measures because his drug begins to work less effectively.* He alters his life-style: If formerly he was gregarious, he now becomes solitary. He measures his drinking, perhaps buying only half-pints, but his total consumption is not lessened. He goes to great lengths to make sure his drug is always available, and hiding bottles is only one manifestation of this anxiety. He may appear hypomanic (everything is "just great," he insists, when obviously the opposite is true), or he may be deeply depressed. He maintains, or attempts to maintain, forced periods of abstinence, and it is characteristic of the alcoholic that he can detail the exact time and duration of his last period of being "on the wagon."

6. *The alcoholic's social relationships deteriorate.* This is first felt within the family. The patient participates less and less in family activities and communicates less and less with family members. In response, the family members become frustrated, depressed, isolated, and angry, just as does any other family group which is trying to care for a member who has chronic illness. Family members tend to feel a guilty responsibility for the alcoholic, thereby compounding their own illness. Without doubt, alcoholism is a family disease, affecting not only the drinker but also every individual in the family group.

At the same time, the alcoholic's relationships with both friends and fellow workers also deteriorate. His work suffers. His standing in the community suffers.

7. *Signs of regression appear.* The alcoholic isolates himself. His depression deepens perhaps to the point of suicidal ideation. He seeks help from every source which occurs to him: friends, minister, family physician, psychiatrist, community health center, an alcoholism program, AA meetings. He tries to follow the varied suggestions offered, but concludes that none of them will work for him. Fear rises as he experiences these failures.

8. *Physical problems, related to alcohol, appear.* He experiences the symptoms of gastritis, of liver disease, perhaps also those of pancreatitis. Injuries received during intoxication become frequent.

9. *Hospitalizations are required for alcohol-related disabilities.* The severity of physical symptoms from the alcohol-related diseases of the various organs increases so that hospitalization becomes necessary. Falls, burns, and other injuries received during intoxication increasingly require hospital care. Both overdose and withdrawal may become more frequent and severe.

10. *Chronic loss of drug effectiveness becomes evident.* There comes a time when his drug no longer brings the accustomed relief or pleasure; depression develops instead. This occurs unrelated to the amount consumed. All these factors combine to hasten and increase the loss of ego-control. The alco-

holic is badly in need of effective help.

Treatment

Ideally, the disease should be diagnosed and treatment begun not later than the first stage of withdrawal. At that point the progress of the withdrawal syndrome can be halted with comparative ease, the alcoholic is likely to be more than usually willing to enter a program of rehabilitation, and it is not only possible but highly feasible to begin his or her education as to the nature of the disease.

Should the patient first appear in acute stages of withdrawal or before detoxification is complete, we initiate a brief period of outpatient medical management. He or she is immediately entered in the ongoing, new-patient program. Under this plan, the patient can take full advantage of our treatment facilities, and from the very beginning has the opportunity of learning how to cope with his own particular problems without the aid of a self-prescribed drug.

Group therapy, group education, one-to-one counselling, attendance at AA meetings, and family therapy are the chief elements of the program we offer.

In approaching the addict, the first major task may be to cut through his denial. Information from a carefully-taken history will enable us to do this. During treatment it may be necessary to ask the pertinent diagnostic questions over and over again, not to reconfirm diagnosis but to dissolve the patient's established pattern of denial and refusal to face the realities of the disease.

To counter evasions it is necessary to ask questions in the right way. For example, not "Did you ever attend an AA meeting?" but instead, "When did you first go to an AA meeting?" Then it may be necessary to point out that no one ever attends such a meeting for purely social reasons.

Conclusions

Addictionology is still a very young specialty in the field of health care. To all intents and purposes it is only a little more than five years old beginning with the era of increased emphasis on treatment of addiction. We feel that it is our responsibility to both learn and teach about addiction. Every individual suffering from the disease of addiction should have access to both education as to the nature of addiction and treatment of his disease. ■

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PEDIATRIC ASSISTANTS TRAINED AT GEORGIA STATE AVAILABLE IN JUNE

In June, 15 candidates will receive associate of science degrees as pediatric assistants from the Georgia State University School of Allied Health Sciences. Upon completion of a written examination offered jointly by the American Academy of Pediatrics and the American Association of Medical Assistants, these candidates will become certified "medical assistants in pediatrics."

The pediatric assistant completes a seven quarter curriculum which includes basic college courses such as math, English, human anatomy and physiology and microbiology, and courses directly related to the medical office and ambulatory child health care—terminology, ethics, secretarial practices, laboratory and basic patient care procedures, growth and development and childhood illnesses. A minimum of 300 clock hours are spent in supervised practice in the offices of pediatricians, allergists, pedodontists and child health clinics. Practicing physicians and pedodonists within the community hold faculty rank and serve as clinical preceptors.

The combination of general medical office procedures with the pediatric specialty provides a worker who can be utilized effectively by the pediatrician and the family practitioner. Persons interested in employing the "medical assistant in pediatrics" or in the education program are requested to contact: Mrs. Betty Jo Parsons, M.N., Dept. of Pediatric Assistants, School of Allied Health Sciences, Georgia State University, Atlanta, Ga. 30303; telephone (404) 658-3038.

editorials
editorials
editorials

Am I My Brother's Keeper?

WHEN THE COUNCIL of the Medical Association of Georgia endorsed a "Disabled Doctors Plan" recently a pioneering program was set into motion which will benefit the entire medical profession within the state. Georgia becomes the seventh state in the Union to initiate such a plan which will help the physician who is addicted to, or is significantly abusing alcohol or other drugs. It is interesting to note that other professions including the clergy have organized such programs which are responsive to the needs of their peers. Because of our traditional role in ministering to the needs of others, it becomes difficult for us psychologically to initiate efforts to obtain help for ourselves.

We are fortunate to have a structured and functioning committee operating under the aegis of the Medical Association of Georgia whose purpose is to identify doctors who are disabled by reason of their addiction to or abuse of drugs including alcohol. This group is staffed by a highly qualified and motivated group of our own physicians who have volunteered their services to help us individually and collectively in coping with this very real and pressing problem. They are prepared to make considerable personal sacrifice in terms of travel time and energy. Their program of help is non-judgmental and non-punitive. It has two main thrusts: first, the identification of doctors who truly need help; and second, to try to show these persons how and where they may voluntarily seek treatment and ultimately be rehabilitated. The program is structured to protect the dignity and anonymity of those in need and to spare them embarrassment to the fullest extent possible. The details of the program are outlined in papers elsewhere in this issue.

The Disabled Doctors Plan has been heartily endorsed by your Council to the extent of allocating funds in the amount of $4,000 for eight months operation. With the functional integrity of our peers and our whole profession at stake, let us no longer ask, "Am I my brother's keeper?"

EW

Let Us Stand Seemly, Let Us Stand In Awe

"The longer you can look back, the farther you can look forward."
Winston Churchill

MEDICINE IS AS OLD as Man. The practice of medicine, that unique mixture of art and science, has a glorious heritage of creativity and development. Today the student struggles with the present, tomorrow, on his own, he will

worry about the future. Of what concern is the past? Who cares what Boerhaave did?

Medicine was not born by revolution, but by evolution. Surgery was not created fully developed in the latest edition of the current textbook; it was born after a hard delivery, travelling many roads leading to both triumph and failure. It was helped on its way by other sciences that did not themselves seek the same goal, but could point out dangers on one hand and short cuts on the other.

The history of medicine is filled with pain, hard work and crushing defeats. It is filled, too, with happy accidents and brilliant success. Students can not participate in all of the defeats and successes, but they must know that they happened. Students can participate through the dedicated teacher who will emphasize that the past is not dead by quoting Hippocrates, "The physician should know what the physician before him has known, if he does not wish to defraud himself and others."

Do we have the right to deprive the student of this wonderful collection of human experiences? It is beautiful to know the evolution of modern gastrojejunostomy because, knowing the history, the judgment for performing the operation will be more sound, and the technique itself will be perfect.

We often confuse the surgical progress of our generation with the surgical progress of each new surgeon. Even though the profession has solved many of the older problems of biliary and gastric surgery, and has now moved on to problems of organ transplantation, the young would-be surgeon is as uninformed as one born in 1882. Each individual surgeon, to attain the level of knowledge of the present, must relive, at least by reading, the entire recent history of surgery. One can face the medical problems of today with ease if one knows how the problems of yesterday were solved. The men who solved them are often forgotten, but they can live again to help the young Asclepiad achieve new heights of scientific and professional success.

Every medical school should have a chair of the history of medicine as a necessary part of a sound medical education, as well as in homage for the physicians who have opened frontiers and lifted horizons so that we can see new frontiers and new horizons to reach. Medicine develops by logical experience, but it also develops by the inspiration of great men who have brought us to where we now stand.

Whenever Boerhaave mentioned the name of Sydenham, he removed his hat. It is time for us to remove our hats and to stand seemly and in awe before the great physicians of the past.

John E. Skandalakis, M.D., Ph.D., F.A.C.S.
Stephen W. Gray, Ph.D.
Joseph S. Rowe, Jr., M.D.

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Repeat Coronary Revascularization

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BYPASS SURGERY for coronary arterial occlusive disease was demonstrated in 1968 to be an alternative approach for management of patients whose symptoms could not be controlled with maximal medical therapy. In the ensuing years, there has been a profusion of data relative to whether or not this form of therapy was effective. Strong opinions can be found on both sides of the issue. Perhaps the single fact that both sides share in common agreement is that there have been a tremendous number of bypass operations performed. Data generally accepted from many surgical series showed that between 70 to 80 per cent of patients are relieved completely of their symptoms of angina pectoris with an additional 10 per cent who underwent surgery whose symptoms are improved. It is to this last group that the remainder of this discussion shall be directed.

Patient Population

In the last two years, ten patients at the Emory University Hospital or at the Carlyle Fraser Heart Center at Crawford Long Hospital have undergone repeat coronary revascularization. The age range of this group was 32-63 years. There were six males and four females. The interval between the original operation and the repeat operation varied from six weeks to six years. Six of the patients had their original revascularization performed in the Woodruff Medical Center. They came from a group of over 780 patients undergoing coronary surgery during that interval. An additional four patients had their original bypass surgery in different facilities. There has been no operative mortality in the group undergoing second operation. One patient experienced a presternal abscess which required drainage and healed promptly by secondary intent. This was the only morbidity in the group of ten.

Indications for the first revascularization procedure were angina pectoris in eight patients and angina plus congestive heart failure in two patients. The initial surgery procedure had consisted of single vein graft in five patients, double vein graft in three patients, and triple vein graft in two patients.

Although the interval between the initial and repeat operations varied widely, all the patients had experienced recurrence of their anginal symptoms early after their initial procedure: four patients within the first four weeks following surgery and the remaining six patients within ten weeks. Although the anginal pattern in a given

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Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

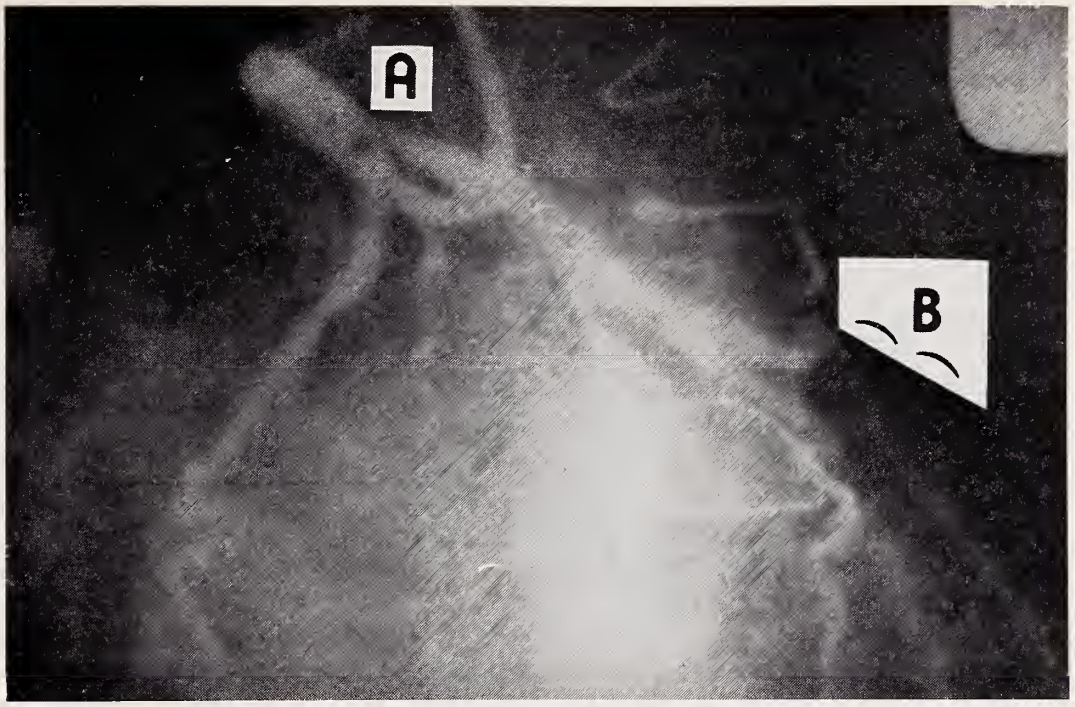


FIGURE 1

Repeat left coronary angiogram in right antero-oblique projection showing new left main stenosis, (A) kinking of formerly grafted artery, (B) and nonvisualization of bypass graft.

patient may have varied from what was experienced earlier, it was, clearly to the clinical observer, of myocardial origin.

The results with medical management of recurrent angina pectoris in this group of patients were as follows. Two patients could be controlled for a prolonged period of time by reinstituting long-acting nitrates and Inderal with thyroid ablation by radioactive iodine. They were not initially considered to be candidates for repeat surgery by their referring physicians. Five patients were poorly controlled on maximal conventional medical therapy. Three patients were uncontrollable on large doses of conventional drugs as well as narcotic analgesics. These eight were felt to warrant early reinvestigation.

Reinvestigation

All ten patients were classified as unstable angina by consulting cardiologists. All experienced progressive angina or increasing symptoms at rest. At coronary arteriography, all vein grafts were found to be closed in seven patients; two patients had the presence of one patent graft having undergone multiple graft procedures earlier; and one patient had developed a significant occlusion in the right coronary artery which had no significant lesion on the original angiography. The grafted or host coronary artery could not be visualized in two patients, was found to be stenosed at the distal anastomotic site in two patients, and was unchanged in the remainder of patients. In addition, new coronary arterial occlusions representing greater than 75 per cent luminal narrowing were demonstrated in over 70 per cent of the patients. Left main occlusions were demonstrable in three; circumflex coronary artery occlusions in four; left anterior descending occlusions in three; new right coronary occlusions in two; and no change in the vascular pattern was demonstrated in four. Figure 1 demonstrates several of these problems. You will note that the projection is a left coronary arteriogram in the right antero-oblique projection. The sternal wires from the previous sternotomy closure are evident as well as the cardiac catheterization catheter present in the left coronary ostium. The contrast material demonstrates the new left main stenosis proximal to the point that the left main coronary artery divides into the left anterior descending and left circumflex branches. Also distally, in the left anterior descending, one can see the stenosed artery that is now kinked as though it were being retracted and clearly

narrowed at the graft site. No opacification of the previously constructed graft is visible.

Repeat Revascularization

Repeat coronary revascularization was performed using cardiopulmonary bypass, systemic hypothermia, and intermittent anoxic arrest. The midline sternotomy was reopened in every case. The vessels bypassed at the second operation were as follows. Four patients underwent bypass to the left anterior descending coronary artery alone. Five patients underwent grafts to the left anterior descending and one other coronary artery. The internal mammary artery alone was used in two patients. The internal mammary artery plus a saphenous vein graft were used in three patients, and multiple vein grafts were constructed in five patients. There was no operative mortality. The patients' recovery following reoperative surgery was no different from those patients undergoing primary revascularization.

Current Patient Symptoms

Follow-up was obtained from four weeks to two years postoperatively. Seven patients relate that they are experiencing no angina. Three patients are experiencing mild angina controllable on medical therapy. Four patients have undergone repeat coronary angiography following their repeat revascularization. All patients had patent grafts to the left anterior descending coronary artery. Two of three grafts were patent to other vessels in these patients. A single vein graft to the isolated right coronary artery lesion was found not to be patent.

Reoperative graft patency following repeat revascularization was felt to be promoted by a better approximation of the diameter of the new graft to that of the diameter of the host coronary artery. Routinely, the saphenous veins from the lower leg are now being used for grafts rather than those from the thigh. Figure 2 demonstrates how the vein from the lower leg more closely approximates the diameter of the coronary arteries in contrast to the thigh vein. It is felt by Savage and coworkers that a large disparity between graft and artery promotes early graft occlusion due to turbulence and eddy currents produced at the anastomotic site. The increased patency when the internal mammary artery is used as a graft is well documented. Minimal dissection and mobilization of the coronary artery to be grafted is now performed. Previously the arteries were thoroughly mobilized and occasionally even suspended with vascular loops. This practice is felt to have caused the kinking problem demonstrated in Figure 1. More wide use of operative magnification to construct the distal anastomoses improves the operative precision.



FIGURE 2

Comparison of graft size between saphenous vein from thigh (L) and vein from lower leg (R).

The procedure is obviously made more difficult than originally by the very extensive scarring which results from the previous surgery, by the inaccessibility of some of the vessels due to the scarring, and by damage to the artery to which grafts would be placed from the previous operation.

Summary

For those patients who develop recurrent symptoms after initial myocardial revascularization, the principle of therapy should be that they are treated as if they are new patients. Initial therapy should be along conventional lines with long-acting nitrates and Inderal; Digoxin and antiarrhythmic drugs should be employed if indicated. If the patients are not controllable on this regimen, prompt repeat coronary angiography should be performed, and revascularization considered if the coronary anatomy appears to be operable and the left ventricular function adequate as demonstrated by an ejection fraction greater than 30 per cent. Findings described by the surgeon at the original procedure may be very important in this decision. By utilizing these criteria and with the knowledge of the fact that the procedure can be conducted safely with good results anticipated in the majority of patients, we should not hesitate to recommend repeat coronary revascularization. ■

CARLYLE FRASER HEART CENTER DEDICATED

The new multi-million dollar Carlyle Fraser Heart Center of Emory University's Crawford W. Long Hospital was dedicated in ceremonies February 22, attended by Gov. George Busbee, Lt. Gov. Zell Miller and several Emory officials.

The heart center, named for the Atlanta businessman, civic leader and humanitarian, occupies two floors of the new Peachtree building of the Crawford Long Hospital plus one floor in each of two other hospital buildings—the Agnes Raoul Glenn Memorial Building and the Davis-Fischer Building.

Three major divisions of the Carlyle Fraser Heart Center include a diagnostic center with a heart catheterization laboratory and facilities for exercise testing, echocardiography and other diagnostic procedures; a surgical suite for all types of heart and blood vessel surgery including open-heart surgery; and a patient care area with two intensive care areas—one for acute coronary care patients and the other for open-heart surgical patients.

Two days preceding the ceremony, the hospital played host to Joseph Reeves, M.D., former chairman of the Department of Medicine at the University of Alabama Medical Center in Birmingham who now is in private practice in Beaumont, Texas. Dr. Reeves conducted a conference on heart disease, made rounds with attending physicians and spoke on heart disease at an evening banquet.

ILLITERATE POPULATION OF GEORGIA DROPS BUT SOME SCHOOL SYSTEM FAILURES SHOWN

Georgia's illiterate population 14 years of age and over decreased sharply between 1960 and 1970, according to a study completed recently by Emory sociology professor Abbott L. Ferriss. He reports an estimated 121,570 residents were illiterate in 1960, but that the number had dropped to 67,110 by 1970. This represents a decline in the illiteracy rate from 4.5 per cent in 1960 to 2 per cent in 1970. The rate for the nation as a whole in 1970 was 1.2 per cent, down from 2.4 per cent in 1960.

Dr. Ferriss cites three reasons for the decrease in Georgia's illiterate population: 1) the death, during the 1960s, of some 22,000 illiterates; 2) migration out of state of approximately 23,000; and 3) some 14,000 residents who have been taught to read in the Adult General Education Program initiated in Georgia in 1964.

A startling addition to the illiterate population during the 1960s is an estimated 6,430 who by 1970 had reached 14 to 24 years of age. These are failures of the school system. Dr. Ferriss points out that approximately 10 per cent of the 1970 illiterates in the state were produced during the 1960s and late 1950s. Some young illiterates may have migrated to Georgia from other states.

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The Disabled Physician in Georgia

J. WINSTON HUFF *and* ERIC CARLTON, *Atlanta**

SEVERAL STATES recently have passed legislation dealing with the problem of the physician who has become unable to continue practicing medicine competently due to physical or mental disability. The purpose of this legislation is the identification and removal from practice of physicians whose competence has become impaired by reason of physical and mental disease, injury, senility, and the most pervasive and difficult forms of physician disability, alcoholism and drug addiction.

In its 1974 amendments to the Medical Practice Act, the Georgia General Assembly also has taken a new look at the problem of the disabled physician. This article will present a summary of the statutory treatment of the disabled physician in Georgia, as well as an overview of malpractice liability for the disabled physician and his colleagues.

Administrative Sanctions

The Composite State Board of Medical Examiners, the 12-member administrative board of physicians charged with regulation of the practice of medicine in the State of Georgia, assumed authority in 1970 for the licensure of physicians holding both M.D. and D.O. degrees from the State Board of Medical Examiners and the Board of Osteopathic Examiners, respectively.[1] Prior to the 1974 amendments, the Board of Medical Examiners had statutory authority "to suspend for a definite time to be determined by the discretion of the board," or to revoke the license of a medical practitioner who had become subject to "habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to render [him] unsafe or unfit for the performance of his professional duties" or who had sustained "any physical or mental disability which renders the further practice of medicine dangerous."[2] Osteopaths, prior to merger of the Board of Osteopathic Examiners into the Composite State Board of Medical Examiners in 1970, were subject to revocation of their licenses by the Board of Osteopathic Examiners on the vague grounds of "grossly unprofessional conduct," or addiction "to any vice to such a degree as to render [the practitioner] unfit to practice osteopathy,"[3] with no reference being made to any other disability.

The creation of the Composite State Board in 1970 brought M.D.'s and D.O.'s under common regulation with the disciplinary standards formerly in effect for M.D.'s made applicable to both groups of physicians. And, as noted previously, the 1974 amendments to the Medical Practice Act[4] re-examined the problem of the disabled physician and established definite procedures for license revocation, suspension, and reinstatement. Currently, the Board may revoke or suspend the license of a physician or take other appropriate disciplinary action if it finds he has

> "become unable to practice medicine with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition."[5]

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner and Mr. Carlton is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, Atlanta, Ga. 30303.

The revised statute vests the Board with power to require any licensed physician, "upon reasonable grounds," to submit to a mental or physical examination, the results of which are available to the Board. Refusal to submit to such an examination may in itself constitute grounds for disciplinary action. In addition, the Board has power to obtain "any and all records relating to the mental or physical condition" of the physician for its use in disciplinary proceedings. At a hearing, the Board has power to revoke, suspend, or limit the license of the subject physician, to issue a public or private reprimand, or to condition any penalty upon the physician's submission to professional care, counseling, or treatment. Thus, the Board has the flexibility to fashion an appropriate remedy suitable for each individual physician found to suffer a disability.

The Medical Practice Act also deals for the first time with the question of reinstatement of the license of a suspended physician. Any physician whose license has been suspended due to alcoholism, drug addiction, or other disability is to be afforded "at reasonable intervals" the "opportunity to demonstrate to the board that he can resume . . . the practice of medicine with reasonable skill and safety to patients."

Several other states have passed legislation specifically requiring physicians who have knowledge of the physical or mental disability of a colleague to report any information they have to the appropriate licensing authorities for consideration. Although the Georgia statute does not appear to require physicians to report such information to the Board, a physician who has "knowingly maintained a professional connection or association with any person who is in violation" of the Medical Practice Act or who has "knowingly aided [or] assisted" any person to practice contrary to the Act may himself be subject to disciplinary action.[6] Thus, physicians whose partners or colleagues in professional associations or corporations are known to them to have become unable to practice with reasonable skill and safety may themselves be in violation of the Act unless they at least terminate their association. Furthermore, physicians collaborating with or referring patients to a disabled physician may be considered to be associated with or to have aided or assisted such physician.

Civil Liability

The fact that a physician may be an alcoholic, a drug addict, or otherwise disabled, without more, is insufficient evidence to support a verdict of malpractice; as in all actions for malpractice, the plaintiff patient must prove (i) that his damages are the direct result of the defendant physician's treatment and (ii) that such damages would not have resulted had the physician provided the level of care common to medical practitioners under the circumstances (the "standard of care"). However, evidence of alcoholism, drug dependence, or other disability on the part of the defendant physician, even if such disability may not have legally caused the plaintiff's damages, would certainly have a profound and devastating adverse affect upon a jury. In addition, punitive damages, which may be awarded in cases of "aggravating circumstances,"[7] might possibly be assessed against a physician practicing under the handicap of an obvious disability.

Civil Liability of Others

The negligence of a disabled physician may in certain circumstances result in liability of another physician to the injured patient. As in all cases, partners and collaborators in a given course of treatment may be liable for the malpractice damages of their colleagues. In addition, the Georgia Court of Appeals has ruled that where two physicians have treated a patient, malpractice is shown, and damages cannot be attributed to one or the other or apportioned between them, *both* may be held liable to the injured plaintiff.[8]

A physician who knows or should know a colleague is suffering from a disability which he knows or should know will adversely affect that physician's performance may be liable for his *own* negligence in referring patients to such physician or permitting his patients to undergo treatment by the disabled physician. Similarly,

hospitals employing physicians they know or should know to be alcoholic, drug addictive, or otherwise disabled, may be liable for negligence in employment, insofar as the Georgia courts have decided that hospitals may not rely upon the mere fact of licensure by state authorities in hiring staff physicians.[9]

Conclusion

The amendments to the Medical Practice Act authorizing examination of physicians whom the Composite State Board of Medical Examiners has "reasonable grounds" to suspect may have become unable to practice in a competent manner by reason of alcoholism, drug addiction, or other mental or physical disability, should provide an effective mechanism for the investigation and disposition of complaints alleging disability on the part of a physician. At the same time, the liberal reinstatement policy of the Act should insure that disciplined physicians have the right to resume their practice when their disability has been removed. However, the reforms can work effectively only if violations are brought to the attention of the Board by physicians and laymen within the state and if a vigorous enforcement policy is pursued by the Board. ■

REFERENCES

1. 1970 Ga. L. 301, 303, as amended; Ga. Code Ann. §84-902.
2. 1957 Ga. L. 129, 130; formerly Ga. Code Ann. §84-916(5), (15).
3. 1909 Ga. L. 123, 129; formerly Ga. Code Ann. §84-1210.
4. Ga. Code Ann. Ch. 84-9.
5. 1974 Ga. L. 1156, 1165; Ga. Code Ann. §84-916(a)(13).
6. 1974 Ga. L. 1156, 1164; Ga. Code Ann. §84-916(a)(9).
7. Ga. Code Ann. §105-2002.
8. *Gilson v. Mitchell,* 131 Ga. App. 321, 205 S.E.2d 421 (1974); *aff'd.,* 233 Ga. 453, 211 S.E.2d 744 (1975).
9. *Joiner v. Mitchell County Hospital Authority,* 125 Ga. App. 1, 186 S.E.2d 307 (1971); *aff'd.,* 229 Ga. 140, 189 S.E.2d 412 (1972).

HIGHLIGHTS OF EXECUTIVE COMMITTEE

February 15, 1976

Update on Medicaid Lawsuit: MAG legal counsel reported that the Association's lawsuit against the DHR-Medicaid has been assigned to Federal Judge William O'Kelley and it is hoped that a hearing on the case will be scheduled during the next couple of weeks. Judge O'Kelley previously had denied a request for a temporary injunction filed by MAG. It is anticipated that the MAG suit will be combined with a similar suit filed by the Georgia State Medical Association. The MAG position against signing the Medicaid Provider Agreement was reaffirmed.

Social Security Account Numbers: A request was received from the Medical Society of the State of New York for support of the concept not to use the SSAN as an identifier for purposes other than that which were intended originally. The Executive Committee passed a resolution opposing the concept for use of the SSAN on all hospital records so that the Bureau of Quality Assurance could tie medical records to an individual physician.

Conductive Floors in Operating Rooms: Passed a motion supporting the position of the anesthesiologists that conductive floors are not necessary wherever non-inflammatory anesthetics are used. DHR regulations for new hospitals requiring conductive floors in these areas have been ruled obsolete by the American Fire Protection Agency.

Status of State Legislation: Professional Liability—it was reported that the MAG-supported legislation is progressing through the legislative labyrinth in a form which is favorable to MAG's position. HMO—DHR also opposed to this bill since the federal regulations have not been issued. Hopefully, no action will be taken this year. HM1705 requires the pharmacist to substitute the least expensive drug unless he is instructed by the patient not to. MAG will oppose its passage. The Medical Practice Act Amendment making the practice of medicine without a license a felony rather than a misdemeanor is moving along.

It was reported that the Georgia Psychiatric Association is supporting actively MAG legislative activity. Executive Committee approved a letter of commendation and appreciation to the GPA in recognition of their efforts.

MAG Services, Inc.: Heard a report that the print shop is open and in operation.

Appointments: Medical Nominating Commission for the Board of Human Resources—Robert P. Coggins, Marietta; Warren Dickey Stribling, Gainesville, and William C. Collins of Atlanta. Interprofessional Council—Alvin W. North of Atlanta, reappointed; Lawrence L. Freeman, Chamblee. Committee on Laboratory Quality—Earnest J. Jones, Decatur and Lucien Tatum of Griffin. Ad Hoc Committee on the Bicentennial—Russell Moores of the Medical College of Georgia in Augusta and Mr. Gerald Cates of the University of Georgia.

I've told this before

(Ed. note: Author J. G. McDaniel gives us an insight into human nature this month with the story of a housewife who had to make a choice between two "evils." Contributions are solicited and should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Misery Loves Company

MRS. SMITH WAS A short, round woman who looked fortyish, blondish and in perpetual need of a beauty parlor expert. She had a sad expression that lighted up only if someone asked her how she felt or how things were going at home. To either question Mrs. Smith would answer as long as one cared to listen.

Her ailments were many and varied and according to her had confounded all the medical experts in the city. Certainly none of them had been able to benefit her and nearly all agreed that her problem was with her husband. She knew in her heart that this was probably true.

Mr. Smith was a good provider and when he was sober, or reasonably sober, was a man of some charm. He was a fairly nice looking person, as men go. He always reported to work on time and sober, but on the way home he and some of his friends always stopped by a tavern to drink. Mrs. Smith never knew exactly when he would be home or in what shape he would be. She never knew if he would eat so much junk he would not be hungry when he got home therefore not wanting the meal she had prepared and kept warm for him. Just as certain as anything in the world, if she did not have a meal waiting, he would come home hungry and raise cain because dinner was not ready. Weekends were the same, she never knew what to expect. He never went with her anywhere and usually consumed one or two bottles of whiskey.

But Mr. Smith wasn't all bad. He never did "beat her up." If he became sorely aggravated he might give her a pretty good slap on the backside. He never chased around with other women and Mrs. Smith frequently complained to neighboring women about his taking care of his home duties too well, especially over the weekend.

People were kind and solicitous to Mrs. Smith. The preacher was always sympathetic. Friends always stopped her and asked "how things were" and told her about a place reserved in heaven for her. Seldom a week passed, but what friends called on her, some bringing a cake or fruit or other goodies. They listened attentively to her tales of woe.

Then one cold, rainy winter night, Mr. Smith got pretty much of a load on and came home wringing wet and about to freeze. The next morning he had a high fever, bluish color and looked like he was going to die. The doctor said he had pneumonia and immediately gave him large doses of antibiotics.

Over the next few days, Mr. Smith's fever subsided, he looked and felt better, but for no reason at all suddenly commenced screaming that a big gorilla was after him. There was no doubt that he was frightened, his countenance registered mortal fear. The doctor said he had *delirium tremens* (DTs) and instructed her to give him a little whiskey, but for some reason, his stomach refused it. This went on for several days. All kinds of varmints got after him, but the main one was a horrible gorilla.

Mr. Smith quit drinking any kind of alcohol and became a model husband. The preacher said that this was in answer to all the prayers that were said for him. Some of the neighbors said that it was because his stomach so violently refused it when he was delirious. The doctor said that all of this helped but after his de-

lirium had passed he told Mr. Smith that if he ever got into this condition again the damn gorilla would catch him.

Mr. and Mrs. Smith went to church and people would pat Mr. Smith on the back and congratulate him on his victory over John Barleycorn. The preacher and the preacher's wife especially made a big deal out of it. The same thing was true when he went with her to the grocery store. She usually stood in the background and her husband did the talking.

Mrs. Smith commenced feeling a little more and more lonely. People no longer asked about her health and well being. Usually they greeted her with "I know how happy you must be" and inquired about her husband. Friends stopped making pop calls, no one ever brought her a cake or cookies any more. Mrs. Smith lost her appetite and gradually commenced losing weight. She became nervous and had sleepless nights. New clothes and frequent trips to the beauty parlor did not boost her.

And then a strange thing happened. One Friday night when Mr. Smith got home from work, his wife had bought a bottle of his favorite booze, had it with ice, glasses, etc. on a table. When he asked what in the world was going on, she replied that it had been a whole year since he had touched a drop of whiskey and that she thought they should celebrate.

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APPLICANTS SOUGHT FOR MONTH-LONG HUMANITIES/MEDICINE SEMINARS

The National Endowment for the Humanities again will support a program of seminars for physicians and other health professionals in 1976. The seminars will bring medical practitioners together with distinguished humanists from the fields of history, religion, sociology and philosophy for a month of study on such issues as ethical conflicts, the rights of patients and practitioners, the purpose and limits of the medical professions and their relations to the community.

Some 15 participants will be selected from the applicants for each seminar, receiving free tuition and a $1,200 stipend to cover expenses, plus reimbursement for travel up to a $300 maximum. Family members may join the participants, but the stipend will not be increased.

From August 9-September 3 John C. Burnham, professor of history and lecturer in psychiatry at the Ohio State University will conduct a seminar in which participants will identify the historical forces that have shaped the medical profession in the context of Western culture.

H. Tristram Engelhardt, Jr., philosopher and physician who is an associate professor of philosophy of medicine, will direct a seminar September 13-October 8 at the University of Texas Medical Branch at Galveston. The seminar will examine the general issue of patient's rights, in particular the right to health care through a consideration of issues that bear on the status of the individual, the nature of justice and the relationship between the individual and society.

Renée C. Fox, professor of sociology at the University of Pennsylvania in Philadelphia will conduct a seminar June 1-30. This seminar will examine the ways in which social and cultural forces influence current medical phenomena and problems in American society. Among the topics considered will be the hospital as a social system, modern medical research, conceptions of health and illness, and bio-ethical issues in contemporary medicine.

William F. May, professor and chairman of the Department of Religious Studies at Indiana University in Bloomington will conduct the fourth seminar June 28-July 23 on the Stanford University campus in Stanford, California. He will explore basic ways of interpreting human nature and obligation as they affect decisions in medical practice.

Application deadline for the University of Pennsylvania and Stanford University seminars is April 15, with selections announced about April 22. Contact: Prof. Renée C. Fox, Chairman, Dept. of Sociology, 128 McNeil Bldg. CR, Univ. of Pennsylvania, Philadelphia, Pa. 19174; and Prof. William F. May, Chairman, Dept. of Religious Studies, Sycamore Hall 230, Indiana University, Bloomington, Ind. 47401.

Application deadline for The Ohio State University and University of Texas seminars is May 13 with selections announced about May 28. Contact: Prof. John C. Burnham, Dept. of History, The Ohio State University, 230 W. 17th Ave., Columbus, Ohio 43210; and Prof. H. Tristram Engelhardt, Jr., Institute for the Medical Humanities, Univ. of Texas Medical Branch, Galveston, Texas 77550.

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SOCIETIES

The February meeting of the **Bibb County Medical Society** included guest speaker Raymond A. Moody, Jr., M.D., author of *Life After Life*. Currently Dr. Moody is preparing a second book dealing with research on suicide victims unsuccessful in their attempts to take their lives.

New officers of the **Cobb County Medical Society** were installed in January, and include Robert Coggins, M.D., president; Dan B. Stephens, M.D., president-elect; and Evans Nichols, secretary-treasurer. Attorney Lawrence Custer is the guest speaker for the Society's March meeting at the Ramada Inn, Marietta.

Jack Watson, chairman of the Board of Directors, Georgia Department of Human Resources, addressed members of the **DeKalb County Medical Society** at their February meeting. During the social hour preceding the meeting "The Medicaid Crisis" was discussed through informal questions to Sam Thurmond, director of the Georgia Medicaid Division, and Benjamin Okel, M.D. member of the Dept. of Human Resources Board of Directors.

Mr. Thurmond also spoke to the **Georgia Medical Society** in Savannah at their January meeting. In February, the Savannah area physicians heard from Dr. Herbert L. Windom, associate professor of the Skidaway Institute of Oceanography who explained the purposes of oceanographic research.

The **Medical Association of Atlanta** celebrated the Bicentennial with a ball titled "Reflections of History" in honor of their new president L. Newton Turk, III at the Academy of Medicine February 21. The evening's activities included a "Revolutionary Review of Medicine," dinner by candlelight and flowers, dancing and an 18th century game room.

Newly elected officers of the **Whitfield-Murray County Medical Society** include: James R. Gregory, president; James S. Meyers, vice-president; Willard P. Carson, president-elect; William L. McDaniel, Jr., secretary-treasurer. Delegates to MAG are James J. Oosterhoudt, John G. Forshner, Sidney Sellers, with alternates Paul Henson, William L. McDaniel and Robert W. Simmons.

PERSONALS

First District

I. L. Shuman, Jr., has opened an office for the practice of general surgery in Sylvania.

Several Savannah physicians have been elected officers of their hospitals staffs. At Candler General **W. W. Buckhaults** is chief of staff, **Edgar J. Filson,** chief of staff elect; **Stephen J. Lange, Jr.** is secretary and **Thomas L. German** is treasurer.

At Memorial **Eugene P. Bargeron** is chief of staff, **Clifton L. Cannon, Jr.,** is chief of staff elect and **Arnold J. Tillinger** is secretary-treasurer.

At St. Joseph's the new chief of staff is **Carl H. Brennan. E. Debele Maner** is vice president and **Morris A. Kugler** is secretary.

Third District

Max E. Burr of Columbus has been inducted as a Fellow of the American Academy of Orthopaedic Surgeons at the group's annual meeting in New Orleans.

Tenth District

P. D. Webster of the Medical College of Georgia in Augusta participated in a national conference on classification and staging of pancreatic cancer. He has served as a member of the American Joint Committee developing this system of classification.

D. C. Abele and **G. S. Stretcher** of the Medical College recently participated in the meeting of the American Academy of Dermatology in San Francisco. Dr. Abele was a course director for the symposium on mechanisms of clinical disease and presented a seminar on basic immunobiology. Dr. Stretcher presented a paper, "Porphyrias: Mechanisms of Disease."

DEATHS

James H. Byram

Atlanta physician James H. Byram, 77, died January 25. He was a past president of the Medical Association of Atlanta and the Fifth District Medical Society. Dr. Byram was graduated from Emory University School of Medicine and had served on the staffs of Georgia Baptist, Crawford W. Long and St. Joseph's hospitals.

Survivors include his widow, the former Elizabeth Patterson; daughter, Mrs. Beverly M. Shives of Miami, Fla.; sisters, Mary Louise Byram and Mrs. Luther A. York, both of Atlanta; brother, William W. Byram of Athens.

Frank Weitz

Frank Weitz, 65, of Atlanta, died February 14. He was a graduate of the University of Georgia and Tulane Medical School. Dr. Weitz had taught at Emory University School of Medicine and was a member of Phi Beta Kappa, Phi Delta Epsilon and the American Academy of Pediatrics.

He is survived by his widow, Lenore Golden Weitz; daughter, Mrs. Richard Lipshutz; step-daughters, Stephany Schatel and Brenda Gill; son, Edward L. Weitz of New Orleans, La.; step-son, Michael Schatel; sister, Mrs. Human Levy of Savannah; brother, Norman A. Weitz.

MEDIX Sponsor Awarded Citation By Kidney Foundation

The Kidney Foundation of Southern California has awarded a citation to the Burroughs Wellcome Co. "in recognition of enlightened health education through sponsorship of the MEDIX series and the 'Gift of Life' broadcast." MEDIX is a public service television series which provides health care information in an interesting and factual manner. It is sponsored by Burroughs Wellcome Co. and more than 300 state and county medical societies.

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The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

President Ford's all-out attack against rising government spending sustained a major blow with the Congressional override of his veto of a $45 billion health, welfare and labor bill.

The vetoed bill called for $1 billion more than the Administration's budget request and required hiring of 8,000 more Health, Education, Welfare Department employees. Almost $800 million of the increase involves health programs which would receive a total of $3.9 billion for the fiscal year that ends September 30.

Both houses of Congress exceeded the two-thirds vote necessary to override a veto. The tally was 310 to 113 in the House; 10 to 24 in the Senate.

The Administration defeat came despite a last-minute administration offer to compromise by more or less splitting the difference for a $500 million increase.

Ford had said in his veto message the bill was "a classic example of unchecked spending." But Democrats charged the money measure would cut spending below last year's level and not meet inflation-caused increases.

The bill provides more funds for such programs as Community Mental Health Services, Maternal and Child Health, medical research, Alcoholism and Drug Abuse Facilities, Emergency Medical Services, and education of health professionals.

The Congressional vote was preceded by all-out efforts on both sides to line up votes and by vigorous lobbying from affected outside groups.

The HEW money bill is considered the hardest to vote against in Congress because of the multitude of popular programs funded. Asked how the House was able to muster such a vote to override including dissident Republicans, House Majority Leader, Thomas O'Neill, Jr. (D-Mass.) replied simply, "the coming election."

House Majority Whip, Representative Robert Michel (R-Ill.), told the House in the debate that it would be "setting the spending tone for the session."

Meeting With President Ford

Officials of the American Medical Association have met with President Ford and his top health officers to discuss a wide range of health topics including the Administration's new health proposals and federal regulation problems worrying the physicians of the country.

The 45-minute meeting in the Cabinet Room at the White House was described by participants as friendly. "The President listened with interest to what we had to say and his attitude seemed to be sympathetic," said AMA President, Max H. Parrott, M.D.

Dr. Parrott said President Ford noted the pressures he is facing to take positions that might disturb some physicians. The Chief Executive made a point of urging the AMA and members of his Administration and White House staff to confer often to resolve differences.

Among the subjects discussed were the President's State of the Union and Budget Health Proposals, government regulations affecting physicians, the Federal Trade Commission move to allow physicians to advertise, costs of medical care, and medical manpower.

President for the AMA, in addition to Dr. Parrott, were Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees; Richard E. Palmer, M.D., AMA President-Elect; James H. Sammons, M.D., Executive Vice President of the AMA; and Joe Miller, Deputy Assistant Executive Vice President.

President Ford was told that his recommended annual four per cent limit on physician reimbursement increases under Medicare poses real problems with the medical profession which must adjust to higher costs of doing business yearly as well as the ever-climbing costs of professional liability insurance.

Ford indicated he understood the viewpoint of the profession on the matter and proposed that Administration officials and AMA representatives meet further on the issue.

The AMA delegation told Ford about the AMA's National Commission on the Cost of Medical Care and invited the President to appoint a representative of his Administration to serve as a member.

There was considerable talk about the supply of physicians, with President Ford evincing special interest in the Foreign Medical Graduate situation and the problems of Americans studying medicine abroad. The AMA officials described the increasing numbers of young physicians entering primary care, now 58 per cent.

The AMA's support of the National Health Service Corps as a principal means of helping physician-short areas was outlined. The voluntary incentives in this program were compared with the "indentured service" aspects of health manpower legislation before Congress that would compel young physicians to serve or to pay back the government for federal aid received by medical schools.

In reply to a question from Ford, the AMA delegates noted the organization's support of federal medical scholarships.

The controversial Utilization Review Regulations were talked about. HEW Secretary Mathews was complimented by the delegation for his reasonable approach and willingness to work with the profession to reach agreement on these rules.

President Ford was told that the AMA could find no scientific basis for the disputed Maximum Allowable Cost proposals for Medicare-Medicaid outpatient drugs. The MAC plan could lead to interference in the practice of medicine by restricting the physicians' prescribing scope and could hurt the quality of health care, the AMA officers said.

The FTC suit to overturn the AMA ban on physician advertising will be contested in court, the AMA as-

serted. The AMA was founded in part to do away with abuses of charlatans and advertising of physicians' services, the Chief Executive heard.

The President sought support for his health programs and expressed confidence the Administration and the representatives of the medical profession could work together to iron out differences and reach accommodations.

Second Opinions

Mandatory second professional opinions have been urged for elective or non-emergency surgery under Medicare and Medicaid by a House Commerce Subcommittee.

The Subcommittee on Investigations and Oversight, which held hearings last fall on unnecessary surgery, charged in a report that there were an estimated 2.4 million unnecessary surgeries performed in 1974 at a cost to the public of almost $4 billion. The procedures led to an estimated 700 deaths, the report said.

Contending that second consultations could cut down "significantly" on unneeded surgery, the Subcommittee, headed by Representative John Moss (D-Calif.) said "such a program would save the government millions of dollars."

Arguments that second opinions would cost money and not necessarily provide a solution and expert assertions that it is difficult to determine what constitutes unnecessary surgery were brushed aside by the Subcommittee in its strongly-worded report.

The report said the lawmakers were impressed with evidence "that prepayment plans for consumers and salaried surgeons help reduce surgery in equivocal situations."

"Evidence was compiled in the Subcommittee's investigation that the fee-for-service mechanism of surgical payment encourages surgery in questionable situations," the report said. "An in-depth study of this should be undertaken" by the HEW Department.

The Subcommittee recommended that HEW immediately undertake a study to determine the differences in health indices, costs and the surgical procedure rates between salaried surgeons and fee-for-service surgeons.

HMO Amendments

Legislation to amend the Health Maintenance Organization (HMO) program "would effectively gut the HMO concept and subvert the original intent of the program," the AMA has told the Senate.

Edgar T. Beddingfield, M.D., Vice-Chairman of the AMA's Council on Legislation, said the House passed HMO amendments "remove important comprehensive services and eliminate characteristics which distinguish the HMO from other prepaid group practices."

The AMA witness testified on the final day of hearings on changes in the HMO program. The House bill eliminates many of the benefits stipulated in the original HMO bill and makes other changes designed to make it easier to set up and operate such pre-paid health systems.

Dr. Beddingfield said the House bill in effect converts a demonstration health delivery program into a mechanism for the federal funding of ordinary prepaid groups.

"If in fact the HMO is to be no different from prepaid groups which have existed without federal funding, then we submit there is no justification for federal funding under the guise of experimentation or otherwise."

Revised UR Regulations

Congress has buttressed the medical and hospital professions' case against the Utilization Review Regulations originally promulgated by HEW.

The lawmakers approved with no dissent a provision making it clear that Congress never intended to require 100 per cent review of all Medicare-Medicaid hospital admissions, a key part of the controversial UR Regulations issued by HEW.

The AMA has challenged successfully the UR Regulations in court. The HEW Department is slated soon to issue revised regulations after court-ordered negotiations with the AMA.

One of the major arguments against the Regulations was that HEW had reached beyond Congress' intent in carrying out the review program. Congress' vote on the amendment to the Medicare-Medicaid laws appeared to back up the protests of the AMA and the American Hospital Association.

Sen. Paul Fannin (R-Ariz.) told the Senate that the original regulations calling for direct review of each Medicare-Medicaid admission "is beyond the scope of what we intended. . . ."

Chairman Russell Long (D-La.) of the Senate Finance Committee said "the idea of requiring that everything in a claim be reviewed is not what we had in mind when we passed the law. It is a technical error that should be corrected, otherwise, there would be needless cost and a great deal of unnecessary paperwork."

Emergency Medical Services

The Administration has opposed a specific extension of the program of federal aid to states and localities to demonstrate ways of improving emergency medical services.

Testifying before the Senate Health Subcommittee, Theodore Cooper, M.D., Assistant Secretary for Health, said such assistance could be handled in the future under the Administration's proposed block grant plan to consolidate 16 existing categorical programs.

The so-called "Financial Assistance for Health Care Act" will give states and localities "the discretion to continue funding according to individual state priorities," Dr. Cooper testified.

Legislation before the Senate to extend the program at costs ranging from $270 million to $416 million are "far in excess" of what is required to demonstrate effective systems for emergency medical services, said Dr. Cooper.

He told the Subcommittee, headed by Senator Edward Kennedy (D-Mass.), that the HEW Department already has ample research authority to carry out improvements in emergency services.

Health Report Shows Improvements

Americans' health continues to improve. Lower infant death rates and longer life expectancy are shown in a State of the Union's Health Report for 1975 submitted to Congress and President Ford by the HEW Department.

Rates of infant deaths in the U.S declined from 29.2

per 1,000 live births in 1950 to an estimated 16.5 in 1974. Over the same period, life expectancy at birth increased by nearly four years. The death rate for heart disease is decreasing.

"The report shows considerable achievement as well as need for improvement," Theodore Cooper, M.D., Assistant Secretary for Health, said. "As a people we are receiving more medical care now than 10 years ago. We have made considerable progress in lowering the income barrier to care. Most of us describe our health as good or excellent."

"Conversely, we may well have a higher prevalence of chronic diseases," Dr. Cooper said. "People are living to the older ages where they develop conditions such as arthritis and diabetes, and we can better manage these conditions medically. Many areas of the country appear to lack adequate supplies of health manpower, and costs remain a burden for many."

The report, Health, United States, 1975, includes data on health care costs and financing, health resources and utilization, and health status. The death rate for heart disease among persons aged 55-64 dropped almost 15 per cent over the past six years. In the same age group, the death rate from cancer rose almost four per cent. Among younger people, accidents and homicide are major causes of death.

"The data suggest that much improvement in health status could come from individual action," Dr. Cooper said. "Most death and disability from accidents are preventable, so are health conditions which are aggravated by excessive use of alcohol and tobacco and by lack of exercise and proper diet. They are preventable primarily by changes in individual behavior. Medical care alone can do relatively little."

Representative Thomas Morgan, M.D., Chairman of the House Foreign Affairs Committee, announced he will retire at the end of this session of Congress. Dr. Morgan, a Pennsylvania Democrat, is one of three physicians in Congress. Despite his Congressional duties, Dr. Morgan has maintained a continuous but small practice in his home town of Fredericktown. The 69-year-old physician has served in Congress for 32 years and as Chairman of the Foreign Affairs Committee for 18 years—longest service as Chairman of any current Committee Chairman in the House. Dr. Morgan focused his legislative interest almost exclusively on foreign affairs. He seldom became involved in legislative health matters. The other physician-Congressmen are Representative Tim Lee Carter (R-Ky.) and Larry McDonald (D-Ga.)

Out-of-town hearings on National Health Insurance have been slated tentatively by the House Ways and Means Health Subcommittee for: San Francisco—March 18-19; Knoxville, Tenn.—March 25-26; Salem, Oregon —May 6-7; and New Orleans—May 20-21. ■

HOSPITAL FIRES ON THE INCREASE; CARELESSNESS USUALLY THE CAUSE

Fires in hospitals and mental institutions are costing more than ever before in history, and the number of fires reported in these institutions is larger, according to the National Fire Protection Association (NFPA).

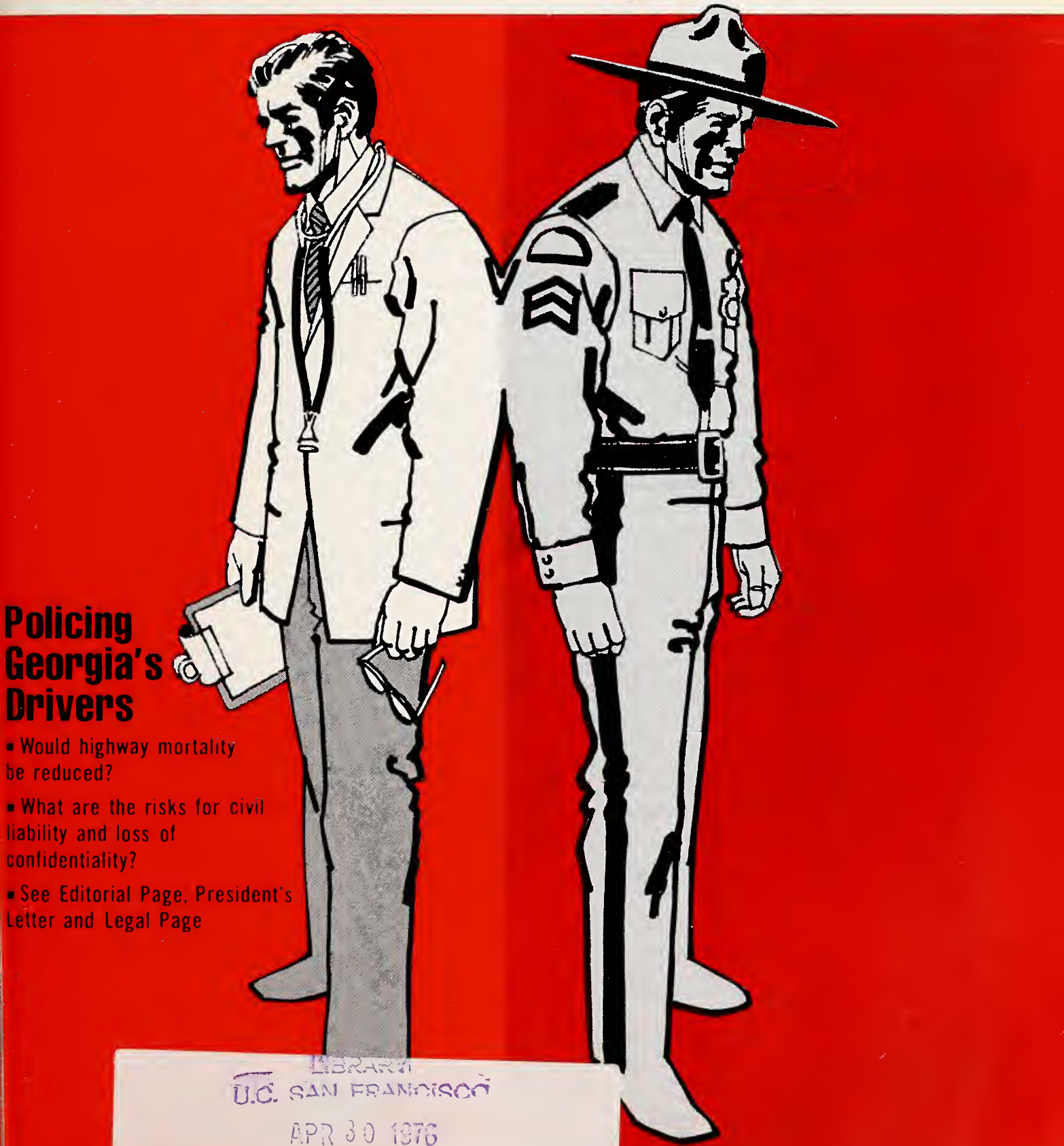
Statistics show an increase of nearly 200 per cent in the number of fires reported in the past six years for a property loss of $79.8 million. Between 1973 and 1974 there was an increase of over 5,000 fires reported in the nation's more than 7,000 hospitals and mental institutions.

Several factors explain the dramatic jump in dollar losses: hospitals have expanded their facilities, increasing the areas exposed to fires; more people are using hospitals; and there is more electrical equipment and much of it is more complex.

The NFPA says only a small percentage of hospital fires are allowed to become serious, but it is these small fires with little damage that should attract the attention of those responsible for hospital fire prevention. Most fires are attributable to careless use of smoking materials. Visitors often are responsible for fires, as they are unfamiliar with the areas in which specific controls are required. Nurses' lounges have been found to be common areas for the wastebasket-type fire. Most fires occur in patients' rooms (55.2 per cent), followed by storage areas (15.3 per cent) and lounging rooms (6.8 per cent). The most common source of ignition is smoking materials (50.8 per cent) and wearing apparel is the material ignited most often (68.8 per cent).

Officials suggest that institutions prepare fire prevention programs and educate personnel, especially those working the night shifts. The most common mistake is neglecting to summon professional help from the fire department before attempting other action.

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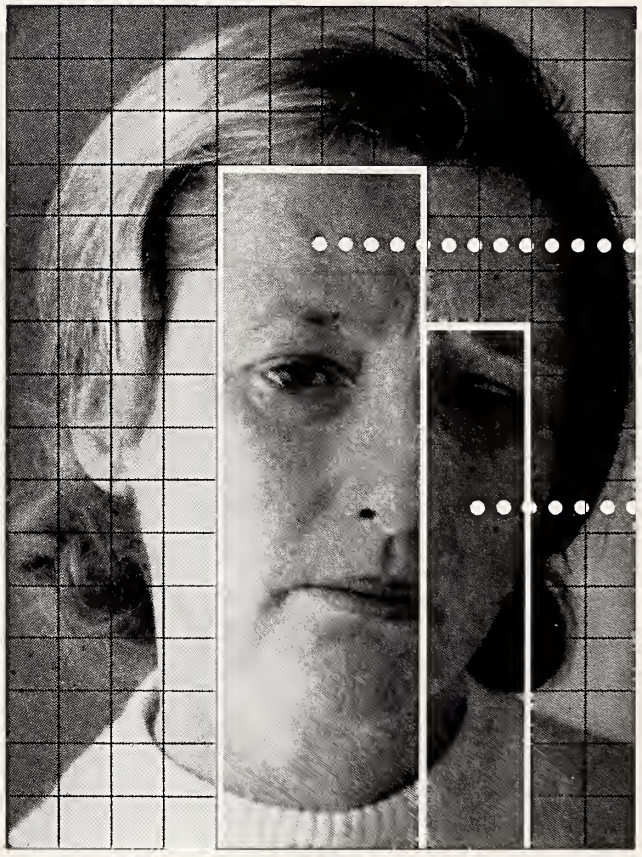


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Consumer Health Education: A New Challenge to the Medical Profession

ANNE R. SOMERS, *Piscataway, New Jersey**

A RECENT CARTOON in *The New Yorker* shows a cemetery, focusing on the Miller family plot. At one side there is the grave of Josiah Miller whose stone reads "1797-1872"; he lived to 75. Then there is old Josiah's descendant, J. C. Miller, whose gravestone is a marble replica of his favorite armchair drawn up in front of his TV set with three empty beer cans alongside. His inscription reads "1930-1973." J. C. lasted only 43 years.

After a half century of steady and dramatic improvement, the overall U.S. death rate ceased to improve during the past 25 years. Between 1950 and 1974 it remained almost stable, fluctuating between 9.7 and 9.1 per 1000 population.[1] The figure for 1974 is 9.1, exactly the same as in 1954. When the population is broken down by age groups, it turns out that mortality rates actually rose, during the sixties, for all ages 15-44. The rise was primarily for men and it was higher for Blacks than for whites. The early seventies have seen a return to the 1960 rate for those 25-44, but for those 15-24 the death rate in 1973 was still higher than it had been in 1960.[2]

Prevention and Delay

The principal causes of death in the U.S. are heart disease, cancer, stroke, and accidents. For young men, accidents, homicide, and suicide are the major causes. Most authorities now agree that the majority of all deaths, except for the elderly, could have been prevented or delayed.

Death is, of course, the ultimate in poor health. It is also the best reported. But it is only the tip of the iceberg. The incidence of nonfatal, preventable heart disease, cancer, stroke, emphysema, cirrhosis, and accidents is enormous. For every youngster killed in an auto accident, hundreds are injured each year, many permanently disabled. For every middle-aged man who dies of cirrhosis, there are hundreds of alcoholics or near-alcoholics. For every death from an over-dose of heroin, hundreds are hooked, perhaps for life, to a habit that will not only wreck their own lives but almost surely cause crime and other problems for their communities.

Health education for the individual is fundamental, if maintenance of good health is to be achieved.

The common denominator in most of this preventable morbidity and premature mortality is individual behavior, environmental factors, and/or both. My theme today is individual behavior or lifestyle. Its primary role in determining the health status of the nation is becoming increasingly clear. Documentation is accumulating at a rapid rate.

Here is one dramatic example: A few years ago, Dr. Lester Breslow, Dean of the School of Public Health, University of California at Los Angeles, conducted studies of 7,000 adults.[3] He and his colleagues followed them for 5½ years. The results showed that seven simple health habits—three meals a day at regular intervals, eating breakfast, moderate exercise, seven or eight hours sleep a night, moderate weight, no smoking, and no alcohol or only in moderation—were associated with longer life.

Specifically, a 45-year-old man who practices 0-3 of these habits can expect to live to about 67. A man with 6-7 of these habits can expect to live to 78, a difference of 11 years.

The study also reported that the physical health of those following all seven good habits was consistently about the same as those 30 years younger

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who followed few or none of these practices. Such findings may sound old-fashioned, quaint, even irrelevant, in this age of open-heart surgery, organ transplants, and other highly sophisticated medical technology. But the facts speak for themselves.

Living a long life is primarily a do-it-yourself proposition! Stated a little differently, the Number 1 health problem in the U.S. today is behavior-related illness and disability.

The full impact of these facts has not yet permeated public thinking. Many legislators, union leaders, and spokesmen for both health care consumers and providers still speak as though the primary barrier to good health in America is lack of financial access. But the steam has gone out of this argument. Certainly, there are many Americans who do not yet have access to quality care, and effective steps must be taken, through national health insurance and other means, to provide them with this access. Certainly, there is need for improvement in the delivery system, and in the education and distribution of health manpower. The fact remains, however, that the primary causes of poor health and premature death in the U.S. today cannot be attributed either to lack of access or shortcomings of the delivery system *per se*. Health care merely patches up the victims of heart attacks, auto accidents, and attempted murder without usually affecting the underlying problems of poor diet, lack of adequate exercise, poor driving, or pent-up violence. A direct attack on the primary causes can only be made by determined efforts at prevention, education, and increased individual consumer responsibility.

The Educational Potential

But, I am constantly asked, what evidence is there that doctors, health educators, or anyone else, can persuade the average American to give up smoking and overeating, to get enough exercise, drive safely, and do what is necessary to reduce the national crime wave?

There are several answers to this question—no one of them conclusive; but taken together, they add up to a persuasive case for at least cautious optimism.

1. There is increasing evidence that millions of Americans do want, and are seeking, additional health information, guidance, and assistance in adopting a healthy lifestyle that is relevant to their individual problems and concerns. Consider for example, the multi-million-dollar business in do-it-yourself health literature, drugs, vitamins, and "health foods"; or the rapid growth of various "behavior change" techniques and movements, including Weight Watchers, Alcoholics Anonymous, Smoke Enders, Transcendental Meditation, etc.; and the popularity of the few good health education programs now in existence.

A 1971 Harris survey, commissioned by Blue Cross Association, reported that 56 percent felt such a need.[4] Among Blacks, persons under 30, and those with less than a college education, the percentage rose as high as 69 percent. Queried further as to desirable ways of disseminating information, nine different sources were endorsed by the majority. The largest vote—80 percent—went for "a system where health information is distributed by doctors and hospitals on a regular basis."

A 1974 survey of over 400 families in a typical middle-income community in central New Jersey found 61 percent interested in attending at least one formal health education program.[5]

Lifestyle Can Change

2. There is already evidence that, when the people are given good firm guidance, a significant proportion are prepared to change their health-related lifestyle or behavior. Fifty-two percent of men smoked cigarettes when the Surgeon General issued his report in 1964; preliminary figures for 1974 indicate the figure is 42 percent.[6] In other words, non-smokers are now in the majority—a fact that still has to be impressed on the airlines, restaurants, and other public carriers and accommodations.

This reduction is smoking is far from ideal, but apparently even a change of this relatively small magnitude has contributed to the important recent reversal in the death rate from coronary heart disease. From 1950 to 1963, the age-adjusted death rate from coronary heart disease rose 19 percent. From 1963 to 1971, it fell 10.5 percent. In the words of cardiologist, Weldon J. Walker, writing in the *Journal of the American Medical Association,* "Certainly there can be a much greater future decline with more effective preventive and educational programs."[7]

Data from one of the largest and most important studies yet undertaken, the Stanford Heart Disease Prevention Program sponsored by the National Heart and Lung Institute and directed by Dr. John Farquhar, of the Stanford Medical School Department of Medicine and Dr. Nathan Maccoby, Director, Stanford Institute for Communication Research, are now becoming available.[8] The objectives of the $4 million, five-year interdisciplinary study, funded by the National Heart and Lung Institute, were to teach individuals between the ages of 35 and 69 about heart risk factors and to stimulate them to adopt more healthful behavior. The study is comparing risk factor reductions in three similar California communities exposed to different mixes of television

spots, printed materials, and personal instruction.

According to the Institute's 1974 report,

> "For the most part, the findings have been extremely encouraging. In general, Watsonville (the maximum-treatment town) has shown substantial change; Gilroy (the mass-media-only town) has changed a little, and Tracy (the control town) has changed negligibly or in the opposite direction. Moreover, within Watsonville, the intensively instructed respondents have changed more than have their randomized controls, who received our campaign messages only through the media and their mail boxes."

Following are examples of changes, as reported by Drs. Farquhar and R. D. Wood, Deputy Director:

- Before the campaign only about 18 percent of the population had even a crude idea about triglycerides. Afterward the figure was 45 percent among the Watsonville participants.
- Cigarette smoking declined about 20 percent in Watsonville but only about 3 percent in Gilroy and was unchanged in Tracy. High-risk persons in Watsonville cut their smoking 40 percent.

These results led Drs. Farquhar and Wood to conclude that an educational campaign directed at an entire community can produce "striking increases in the level of knowledge of heart disease and risk factors and very worthwhile improvements in risk factor levels."

Ideal Time to Cut Back

3. The new economic climate could help to provide additional individual motivation. The recent decline in discretionary income, the food and fuel crises, and general belt-tightening could present health education with its most important opportunity since World War II. What better time to publicize the harmful effects of too much marbelized beef? Too many dairy products? Too many cocktails? Too much driving and not enough walking? To realize the possibilities for diet change, one has only to realize that in 1950 the average American ate 50 pounds of beef and, in 1973, 119 pounds.

Getting people to cut back on anything—cigarettes, alcohol, cholesterol, speeding—is difficult, but it is possible. For example, accidents on the New Jersey Turnpike dropped by one-fifth from 1973 to 1974, the first full year for the reduced speed limit, and fatalities were down by nearly half.[9]

4. Finally, the answer is that we really have no choice. Therapeutic medicine, important as it is, has apparently reached a point of diminishing returns. The 10-15 percent increases that we have been adding to our $100 billion health care bill each year—even the portion that is not consumed in inflation—apparently have only a marginal utility.

Consider, for example, the widespread evidence of patient noncompliance with prescribed regimens, a noncompliance rate that is now said to average over 50 percent; the widespread evidence of unnecessary surgery and over-medication; the increasing realization that technical virtuosity is not necessarily synonymous with effective care; the repeated exposes of miserable care in many nursing homes now expensively reimbursed under Medicare and Medicaid; the growing public demand for more attention to the humanities and amenities of death and dying; and of course, the current malpractice crisis which, I am convinced, is related far more to a breakdown in doctor-patient relations and failure of the physician to adequately inform and educate the patient than to any technical malfeasance. (The roles of the insurance industry and the legal profession are, of course, a different story.) All these developments indicate the public's growing impatience with over-emphasis on the technology of medicine and neglect of the patient as a responsible agent in the treatment of his own illness and maintenance of his own health.

Please understand that I am not a therapeutic or technological nihilist. I am well aware of the importance of sophisticated tertiary care. Indeed, I am concerned over the possibility of the development of a real medical nihilism in this country. What I am pleading for is a sense of balance between all of these necessary modalities.

So, before we conclude that health education is a lost cause, let's give it a real chance, a chance that it has never had up to now for reasons that are both internal to the health professions and external—relating to the broader socioeconomic and political environment.

Rebirth of Professional Interest

Reflecting the facts and developments just discussed, there has been a rebirth of professional and governmental interest in health education. For example:

- There is renewed interest in primary care and people-oriented specialties.
- Patient education, especially for those with chronic illness or disability, has been rediscovered in many hospitals and doctors' offices; and medical and hospital journals are devoting increasing attention to it.
- New theories and techniques of behavior change or behavior modification are being developed by psychologists, psychiatrists, and others.
- The Blue Cross Association approved a special White Paper on Patient Health Education, not only endorsing the concept but urging third-party reimbursement therefor. Individual plans are trying to put these principles into effect.
- The American Hospital Association proclaimed

patient education as one of its major priority items for 1974-75.

- The plenary sessions of the American Association of Medical Colleges annual meeting in November, 1974, focused entirely on public health education.
- Needless to say, the emphasis being given to health education by the medical profession in Atlanta this weekend, with meetings on the subject scheduled by the Medical Association of Georgia, the American College of Physicians (Georgia), and the Georgia affiliate of the American Diabetes Association, suggests a significant revival of interest on the part of physicians. Atlanta, as usual, may be a little ahead of the field but I suspect this is symptomatic of a developing national trend.
- Indeed, some physicians and physician groups see patient education as an important bulwark against malpractice suits and the rising costs of malpractice insurance. Evidence varies from a panel on "Risk Control and Patient Education" at the National Conference on Medical Malpractice sponsored by the American Group Practice Association, March, 1975, to the series of informational and risk-sharing booklets being developed on a business basis by a group of doctors in California.[10]

Increasing Government Commitment

The growing interest on the part of both consumers and providers has begun to be reflected at the federal level. Both the National Cancer Institute and the National Heart and Lung Institute are now funding consumer education and prevention programs which, according to an official spokesman, may now total $40-50 million per year. Both the National Diabetes Commission and the National Arthritis Commission, which are seeking to redefine and upgrade public support of these major chronic diseases and cripplers, are devoting serious attention to patient and public education.

Last June, NIH's Fogarty International Center, whose interests include both international affairs and prevention, cosponsored with the American College of Preventive Medicine, a National Conference on Preventive Medicine. A year earlier eight task forces were set up to develop the position papers for the conference. One of these, which I had the privilege of chairing, was on Consumer Health Education. Our report, now being printed, should be available in a few months.[11] Meanwhile the eight task forces, including the one on Consumer Health Education, have been reconstituted as ongoing expert panels, partly to follow through on the implementation of our recommendations, partly to help develop a long-range research and development program for NIH in this area.

Also within HEW, but following a different track, a Bureau of Health Education was set up in 1974 in the Center for Disease Control here in Atlanta. And, just a month or so ago, a private-sector National Center for Health Education was set up in New York City following a year-long feasibility study conducted by the National Health Council with funds from HEW.

Proposed Legislation

A number of the Task Force's major recommendations have already been translated into proposed legislation. Several bills, embodying variations on these themes, have been the subject of recent hearings in both the Senate and House. One, the National Disease Control and Consumer Health Education and Promotion Act of 1975 (S. 1466) has already passed the Senate.[11] It would establish a high-level Office of Consumer Health Education and Promotion in the Office of the Secretary of HEW with adequate status, authority, and resources to carry out policy design and implementation and other collaborative, oversight, and coordinating functions. (The operational activities of the existing Bureau of Health Education would not necessarily be affected.) It would also provide the new National Center with a quasi-public status, similar to that of the Red Cross, and would make available some modest funds for grants and contracts to hospitals, medical and consumer groups, medical schools, and other qualified bodies for research, development, and evaluation of health education programs.

It is also worth noting that the renewed interest in consumer responsibility and health education is by no means just an American phenomenon. On the contrary, many other countries have historically paid far more attention to health education than we have. England, Sweden, Norway and other European countries are now mounting major campaigns against cigarette smoking. The English goal is to make cigarette smoking an activity "which only consenting adults engage in behind closed doors."

The Canadian experience is perhaps closest to ours. There, too, the emphasis in recent years has been almost entirely on therapeutic medicine. In 1974, the Minister of National Health and Welfare published an unusual document, *A New Perspective on the Health of Canadians,* which called for a reordering of national health priorities in favor of "health promotion" as opposed to "health care."[13] Implementation remains minimal but the mere articulation of such a new policy at the highest level of government is significant.

Flash-in-the-Pan?

Whether all this adds up to the beginning of a basic reorientation in the nation's health priorities—whether it presages a real and permanent revival of interest in health education—remains to be seen. It could be just another passing fad, like many we have seen during the past two decades. It is still much too soon to be sure and depends, partly, on factors beyond the control of any of us in this room.

But of one thing I am sure. If there is to be any chance of success; if consumer health education does emerge as a viable, generally accepted, conponent of U.S. health policy, it will be because physicians and other health professionals and institutions with an interest in this exciting but still amorphous new field decide to take it seriously, make it an accepted part of preventive and therapeutic regimens, and insist on the organizational and financial resources necessary to do the job right. Even organizational and financial resources are not enough, however. To "do the job right" also calls for dedicated leadership and a great deal of skill. At sessions this afternoon and tomorrow, sponsored by the College of Physicians and the American Diabetes Association, we will be discussing some of these problems in more detail: concentrating, this afternoon, on education of the general public; tomorrow morning, on patient education.

A Four-Point Action Program

To conclude this general session, I would like to suggest that you do four things:

1. If you do not now have an organized consumer health education (CHE) program in your medical group, hospital, or other health care institution, consider the possibility of starting one. You may wish to set up an inter-disciplinary or inter-departmental committee to study the feasibility. It is not an inordinately expensive proposition although reliable funding will not come about without some special thought and effort on your part.

Assistance is available from several sources, some of it a lot better than others. Since the Federal Bureau of Health Education is right here in Atlanta, that is probably the first place you would turn to. For an in-depth report on the whole subject, you may wish to obtain a copy of the NIH-ACPM Task Force report. For that you should write to the Fogarty International Center, NIH, Bethesda, Maryland.

2. You may wish to consider the possibility of helping to establish a city-wide community center for health education which would focus on preventive education for the general community, possibly tied in with a local television or radio station, possibly including a hot-line for emergency information.

The focus for such a center could be a hospital, a medical school, the medical society, the health and welfare council, or other body. The sponsorship should be inter-disciplinary and representative of both providers and consumers. There is a large potential role for volunteers. One of the most ambitious such programs is now being developed in Pittsburgh with the local Health and Welfare Council as the coordinating body.

3. Consumer health education should be clearly written into the developing state health care plan. Consumer health education already is spelled out as one of the 10 priorities for national health planning in the new planning law, P.L. 93-641. But it is very likely to get lost at the state and local level unless some of the local leadership insists that it be included.

Also, thinking of state legislation, why not explore the possibility of tieing mandatory CHE to any limitation of liability, arbitration system, or other statutory changes with respect to malpractice? I have already noted that some physicians are making the connection. Why not generalize this?

The historical connection between the development of workman's compensation laws and occupational safety and health programs could perhaps be duplicated in a tandem development of a new type of no-fault malpractice law, with some limits on liability, along with mandatory patient education.

4. Finally, I suggest that you consider supporting and helping to improve the legislative initiatives now being made in Congress. I am hopeful that an even better bill will emerge from the House hearings last week. Unless and until that happens, however, I would urge your support of S. 1466, since it has already passed one House and incorporates most of the essential elements.

The major missing link, one which could not be included in the Senate bill due to jurisdictional considerations in that body, is provision for reimbursement under Medicare and Medicaid. This is essential not just for these patients but to set a pattern for health insurance generally. A bill to that effect will have to be developed and put through the Senate Finance Committee. Senator Talmadge and Senator Long, are, of course, key individuals in this area.

If enough physicians, hospital administrators, nurses, and others around the country do these four things, if all of us, working together, can succeed in making consumer health education a routine and respected part of national, state, and local health policy and of community health care, then perhaps there will be a chance to reverse the trend to self-inflicted and lifestyle-related illness and premature death.

Perhaps the next generation of Miller children can expect to live not only as long or longer than their great-great-grandfather, old Josiah, but the same op-

portunity for a long and productive life can be shared by all Americans, Black and white, rich and poor. Knowledge can never fully conquer death—for we are all mortal. But knowledge can conquer a great deal of premature death and unnecessary illness, pain, and suffering. This must be our goal. ■

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1976 YEARBOOK DATA

The 1976 Yearbook of the Medical Association of Georgia will be mailed to active members of the Association with the August issue of the *Journal.* If information concerning your name, address or specialty has been inaccurate in past rosters, and you have not corrected this with our office in the past year, please fill out and send in the form below. If you have changed address recently, or plan to do so within the next few months, you may wish to supply us with the new address for the 1976 Yearbook. Those who have joined MAG within the past six months should provide their medical education number.

Mail to: Yearbook Data
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Medical Education Number: .....

Comments: .....

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"As soon as I had acquired some general notions respecting Physics . . . I perceived it to be possible to arrive at knowledge highly useful in life . . . especially for the preservation of health, which is without doubt, of all the blessings of this life, the first and fundamental one."

René Descartes
Discours de la Méthode, Pt VI.

Improved Patient Care Through Patient Education

MARK E. SILVERMAN, M.D. *and* DONNAH LAMITINA, R.N., *Atlanta**

SUPPOSE THAT YOU are a patient without any medical knowledge and your physician informs you that you have diabetes . . . or pyelonephritis . . . or hypertension. What fantasies and fears might swirl through your mind as you try to cope with these strange words and explain them to your wife or your family? Would you be able to recognize the symptoms of your disease? How would you decide when to call your physician? . . . or go to an emergency room? . . . or take an extra dose of the medicine? Would you be able to distinguish the side effects of the medicine from the symptoms of your illness?

In the past, physicians have provided some patient education; however, their efforts were greatly hampered by lack of time and inadequate educational material and equipment. Hospitals have offered dietary counseling for inpatients but have not been able to instruct many outpatients. National service organizations, such as the American Heart Association and Arthritis Foundation, have produced a plethora of educational material but have not had direct accessibility to patients.

In an effort to educate the patient and assist the physician by producing and providing programs and material for his patients and to utilize the resources of the national service organizations and the hospital, a patient education health center has been developed at Piedmont Hospital, a 350-bed community hospital located in Atlanta. It is the purpose of this report to detail the development of this program in the hope that our approach might be of some help to other groups interested in initiating a similar program.

The Health Education Center

In 1971 an expansion of the hospital and the development of an adjoining office building provided an opportunity to include an area for health education. Funds were obtained from private contributions, the Georgia Regional Medical Program, and hospital funds to equip a health education center that would link the hospital and professional building. This center was designed to provide educational material, study space, a lounge and an audiovisual room for the use of patients, physicians and nurses. Patients could be directed to the center by the physician for specific reading material or for viewing slide sound shows or video tapes prepared by the physicians and patient education coordinator (PEC).

Organizational Structure

A nurse with background experience in in-service education was selected to coordinate and develop programs for chronic disease instruction as well as for preventive medicine. The position was administrated as a division of Personnel and Training with responsibility to the training director and to the physician director of medical education. A patient education committee consisting of two physicians, the director of in-service education, patient education coordinator, librarian, and cardiac nurse clinician was established to oversee the various programs and suggest new directions.

Program Development

The initial activity of the PEC was to develop objectives of the program. After some deliberation, the following objectives were set:

1. To provide a health information and education center for the community.
2. To assist individual patients to develop optimal health.
3. To help the patient and his family understand

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his disease, readjust and reintegrate into the home community.

4. To promote good health by community outreach detection and prevention programs.

5. To establish an evaluation system for patient education.

6. To offer an on-going staff education process.

Since the PEC could obviously provide only a limited amount of education by herself, it was necessary to develop priorities and enlist the aid of other interested people available in the hospital. An analysis of the most frequent hospital admitting diagnoses provided the program priorities. Hospital dietitians, intensive care and floor nurses, the hospital librarian, and physicians were asked to help develop, participate and promote the programs. Four different types of educational programs were constructed.

1. *Health Center Material:*

Pamphlets and films were obtained from local chapters of national health organizations such as the American Heart Association, American Cancer Society, Diabetes Association, Arthritis Foundation, and Tuberculosis and Respiratory Disease Center. Videotapes were produced within the hospital or bought from commercial sources of patient education material. All of the available programs and material were catalogued in the library and lists were sent to the physician's office. Display cases in the hospital lobby, the nursing stations and lounge areas were kept stocked with pamphlets.

2. *Continuing Individual and Group Patient Education:*

Continuing programs on Diabetes, Heart Disease, Cardiac Education, Weight Control, Colostomy Care, How to Stop Smoking, How to Lose Weight, Hypertension, How to Measure Your Blood Pressure, and Systemic Lupus Erythematosus were initiated. These programs were carefully developed and then presented to the medical staff for suggestions and approval. Physicians were asked to refer patients to the program through the use of a patient prescription pad. These programs have usually extended over a number of weeks and utilized behaviour modification techniques and group therapy to achieve results.

3. *Community Programs:*

Community programs on subjects of current interest were planned by the patient education committee and presented in the hospital auditorium each month. Topics have included Breast Cancer, Back Pain, Self-Protection, Common Questions Concerning Females Today, Allergies to Plants and Insects, Hypertension, Sex Education for Your Children, Colds, Flu and Infections, The Hazards of Smoking, and Adjustment Problems of the School Age Child. Hospital personnel are given time to attend these conferences and an effort is made to promote the programs through radio, newspapers, flyers and posters. The programs are video taped and placed in the health education center.

4. *Closed Circuit Television:*

In an effort to provide in-hospital education on a wider scale a closed circuit television communication system is being developed. This system will allow us to broadcast color video tapes on a regular schedule to each patient room as well as to the lounge areas. A television studio is currently being built so that our production capacity will be greatly expanded. It may also be possible to televise the programs to the waiting rooms of the physician's office.

Program Support and Costs

We were fortunate to obtain Georgia Regional Medical Program support for the first three years. In addition we have charged $5 per hour for individual and group instruction. The use of community programs and health center material is not charged. Medicare and some insurance companies will pay for inpatient education. It is unlikely that the program can be fully supported by charging only for individual instruction. If the closed circuit television education programs become established, a small charge may be added to the daily room fee. Patients and physicians have accepted the concept that patient education is an important service that should be charged if the patient is able to pay.

A patient education program can be started and maintained for less than $20,000 per year. This figure would include the salary of a full time director and basic equipment and programs. A successful program requires a talented program director who must be allowed to devote full time to patient education, a hospital administration and Board of Trustees who are committed to the concept of patient education, and a hospital attending staff who are willing to refer patients and work closely with the program director.

Promotion of Programs

Because physicians have not had a patient education service available before, it is initially difficult to establish referral patterns. We have attempted to alter this by presenting our programs for their review and suggestions at regular conferences, providing prescription pads as referral forms, promoting the programs through flyers, posters, and bulletin board displays, presenting inservice conferences with nursing coordinators, visiting office personnel, providing the physician with a referral listing of available programs in the library, and most importantly by giving

him a detailed evaluation of the material presented and the needs and comprehension of the patient. The physician is made aware that the program is based on continuity of care directed by the physician and implemented by the patient education department.

Evaluation of Patient and Program

An initial appointment is made at which time the patient is interviewed and given a pre-test. Individual needs, goals, learning abilities and limitations are assessed and a program is constructed. Some of the programs utilize group interaction and behavior modifications. Other programs rely on instruction utilizing slides, flip charts, movies, dietary analysis and demonstrations. The test is repeated at the conclusion of the program and the results analyzed by a time sharing computer. The questions are designed to assess factual knowledge and behavior. We have developed questionnaires and a computer program that can be utilized by any hospital throughout the state at relatively little expense.

Results So Far

In the first two years a total of 3,724 patients have been instructed. Some 843 persons have attended our community conferences. Thousands of pamphlets have been distributed and an increasing number of patients are being referred by the Piedmont physicians. At this point it is too early to evaluate the impact of patient education on the health of our patient population. We can say, however, that patient and physician enthusiasm toward the program is very high. In addition, we have offered a service that has saved the time of the physician, improved in-service education for hospital personnel, and enhanced the public image of the hospital as a "health center" rather than a disease oriented hospital. ■

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Opportunities for Continuing Medical Education

RECENT ADVANCES IN ALLERGY
May 2-5, 1976
The Homestead, Hot Springs, Va.
Contact: Claude A. Frazier, M.D., 4-C Doctors Park, Asheville, N.C. 28801

1976 SOUTHEAST EMERGENCY MEDICINE CONGRESS
May 3-5, 1976
Fairmont Colony Square Hotel, Atlanta, Ga.
Contact: Registrar, 1976 Southeast Emergency Medicine Congress, 1919 Beachway Road, Suite 5C, Jacksonville, Fla. 32207; (904) 399-0510

AMERICAN ASSOCIATION OF PLASTIC SURGEONS
May 9-12, 1976
Atlanta Hilton
Contact: M. J. Jurkiewicz, M.D., Emory University Affiliated Hospital, 69 Butler St., S.W., Atlanta, Ga. 30303

AEROSPACE MEDICAL ASSOCIATION
May 10-13, 1976
Americana, Bal Harbour, Fla.
Contact: M. H. Goodwin, M.D., Aerospace Medical Assn., Washington National Airport, Washington, D.C. 20001

FRONTIERS IN CARDIOLOGY
May 10-13, 1976
Royal Coach Motor Hotel, Atlanta, Ga.
Contact: J. Willis Hurst, M.D., Department of Medicine, Emory University School of Medicine, 69 Butler St., S.E., Atlanta, Ga. 30303

26TH ANNUAL POSTGRADUATE SEMINAR—MEDICAL SURGICAL DILEMMAS
May 13-15, 1976
Mt. Sinai Medical Center, Miami Beach, Fla.
Contact: Miniver S. Reed, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Road, Miami Beach, Fla. 33140

AMERICAN SOCIETY OF NEURORADIOLOGY
May 19-22, 1976
Peachtree Plaza, Atlanta, Ga.
Contact: A. E. Rosenbaum, M.D., Radiology Department, Presbyterian University Hospital, Pittsburgh, Pa. 15213

NEW CONCEPTS IN HEMATOLOGY FOR THE PRACTICING PHYSICIAN
May 20-22, 1976
New York University Post-Graduate Medical School
Contact: Office of the Associate Dean, NYU Post-Graduate Medical School, 550 First Ave., New York, N.Y. 10016

SOCIETY FOR SURGERY OF THE ALIMENTARY TRACK
May 25-26, 1976
Miami, Fla.
Contact: University of Miami School of Medicine, P.O. Box 520875, Miami, Fla. 33152

AMERICAN GYNECOLOGICAL SOCIETY
May 25-29, 1976
The Homestead, Hot Springs, Va.
Contact: J. G. Moore, M.D., Department of Obstetrics and Gynecology, UCLA School of Medicine, Los Angeles, Calif.

Through seminars, speakers bureaus and publications, volunteer health organizations provide needed information and teach skills.

The Volunteer Health Organization: A Role in Professional Education?

LAMAR S. McGINNIS, M.D., *Decatur**

VOLUNTARY HEALTH organizations, usually well known for their efforts in public education, are frequently extensively involved in professional education. The Georgia Heart Association and the Georgia Division of the American Cancer Society are excellent examples of organizations with long traditions of activity in the field of education for medical professionals. The annual meeting of the Georgia Heart Association is always well attended and offers attractive programs for cardiologists, internists, and family practitioners. The Georgia Division of the American Cancer Society is involved in a variety of roles in professional education, and I will outline below how this one voluntary health organization attempts to achieve its goals in professional education. I am aware of other such organizations that are also active and involved, but have chosen to use the Cancer Society as an example because of my familiarity with its diversity.

The stated objectives of the professional education program of the Georgia Division of the Cancer Society are:

1. To increase the index of suspicion of cancer on the part of the medical profession, as well as the laity.

2. To cultivate a hopeful attitude—a belief in the curability of many types of cancer and of the importance of early detection and treatment.

3. To help members of the medical, dental, nursing, and allied professions acquire the skills needed to detect cancer early and to utilize all available knowledge in the management and care of cancer patients.

4. To coordinate cancer control efforts with all other existing organizations such as the Committee on Cancer of the American College of Surgeons, the Committee on Cancer of the Medical Association of Georgia, and the Georgia Cancer Management Network.

5. To foresee needs in cancer control for the recruitment and training of adequate numbers of professional and para-professional personnel to work in the cancer field.

These objectives are hopefully achieved by a variety of means. Three major seminars are held annually for physicians: The Day of Cancer as a part of the Atlanta Graduate Medical Assembly; the Spring Seminar at Callaway Gardens (concentrating on radiotherapy, immunotherapy, and chemotherapy; and a fall Day of Cancer which was held in Savannah in November, 1974. Annual seminars on nursing care of the cancer patient have been held at various locations over the state, always with excellent attendance by the nursing profession. The professional education program of the Georgia Division has been approved and accredited by the Medical Association of Georgia and the AMA, and physicians attending these programs may receive appropriate credit for time spent.

Delivering Current Information

A speakers' bureau is maintained with expertise on a variety of subjects with presentations being made on request at tumor conferences, hospital staff meetings, and medical society meetings. The "Cancer Page," featured monthly in the *Journal of the Medical Association of Georgia,* offers timely and current information to all physicians in the state on a variety of cancer-related subjects. Films and a selection of printed materials related to current and controversial cancer subjects are kept available and circulated for use in tumor conferences and other continuing education activities for physicians, nurses, dentists, and students in these professions. *"CA, A Cancer Journal for Clinicians,"* has been mailed to all physicians in the state; and "Clinical Oncology," a therapeutic reference book, has been mailed annually to all sophomore medical students in the state.

Seminars and training workships in cancer-related subjects have been sponsored on occasion. Specifically, workshops in proctosigmoidoscopy, col-

* Chairman, Professional Education Committee of the Georgia Division of the American Cancer Society and chairman of the Subcommittee on Continuing Medical Education of MAG's Education Committee. Dr. McGinnis, a surgeon, is in practice at 365 Winn Way, Decatur, Ga. 30030.

poscopy, detection and treatment of neoplasia of the female genital tract, and mammography have been offered in recent years. The Cancer Society has actively supported The School for Enterostomal Therapists at Emory University in an effort to obtain more of these para-professionals for services to patients in our state. Continuing efforts are being made to make medical professionals aware of the support offered to breast cancer patients by the "Reach to Recovery" program; of the support offered to ostomy patients by the "Ostomy Counseling Program"; and of the support to laryngectomy patients offered by our "Laryngectomy Counseling Program." Nursing workshops in breast exam and self-exam and Pap smear techniques have been offered as a part of the breast and uterine cancer program, with the aim of having every female in the state over 35 receive a breast exam and Pap smear within the year.

Joint appointments of regional professional educational chairmen for the Georgia Division of the American Cancer Society, and district liaison fellows of the Commission on Cancer of the American College of Surgeons, have been made in an effort to coordinate the mutual objectives of these two organizations. Approval of hospital tumor programs is encouraged, and these include the establishment of an effective tumor registry and the operation of a clinical tumor conference within the institution with obvious educational benefits for professionals.

National Activities

The American Cancer Society nationally continues to be active in professional education. In January, 1975 a regional conference for medical students was sponsored at Emory with 165 medical students from all over the South attending. The conference was broadly educative in the field of cancer and introduced the students to the activities of the American Cancer Society and the National Cancer Institute. Six training centers in colonoscopy are planned for physicians because of the increasing importance of this adjunct in diagnosis and treatment of cancer. Twelve professorships of oncology have been sponsored for a five-year period in various medical schools, and hopefully others will be forthcoming. Forty professional films are currently available from the national office for professional audiences. A pilot program for instruction in oncologic nursing is being planned. Two national conferences on advances in cancer management and a national conference on gynecologic cancer were held in 1974-1975; and a national conference on radiation oncology is planned for 1976.

Here we have enumerated some of the many areas of professional education pursued by the American Cancer Society. Some may say, is this the primary objective of the Cancer Society? No, this represents only a portion of the many activities of the Cancer Society, and only approximately 7 percent of the state budget is expended in these areas. Some may say, why is the Cancer Society so deeply involved in this area; is this a responsibility of a voluntary health organization? I would reply that the voluntary health organization occupies a unique position in the health care system, being free of governmental control or directives, influenced but not controlled by organized medicine, and basically the ideal of consumer responsibility and involvement. A broadly based offering of educational programs for professionals, practicing in a free society, is a great strength of our system of health care. ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE

March 13, 1976

EMPLOYEES' RETIREMENT PLAN: Approved a new retirement plan for employees which brings the current MAG plan into compliance with new federal legislation governing such programs.

COMMITTEE ON LABORATORY QUALITY: Approved a new charge for this committee, namely, "The Committee on Laboratory Quality was established to study and monitor the quality of performance in physicians' office laboratories through physicians' voluntary participation in existing proficiency testing programs."

AMA MEETING IN ATLANTA: A motion was passed to ask the AMA delegation chairman to invite the AMA to hold an annual meeting in Atlanta the first open year.

GMCF RESULTS OF SELF-EVALUATION STUDY: Received this report with commendation for John R. McCain and Mr. John Voigt of the Georgia Medical Care Foundation for their efforts in preparing the self-evaluation study.

PRISON HEALTH CARE COMMITTEE: Received a report that the committee had met with various Georgia law enforcement agencies and several of the state institutions have agreed to participate in the pilot program.

CANCER REGISTRY: Received a report that funds will be available for the operation of the cancer registry for another year.

MAG SERVICES, INC.: Received a report that the print shop is in full operation at the present time. The majority of work has been in-house but soon after Annual Session a formal brochure will be sent to the membership seeking their printing business.

APPOINTMENTS: Maternal and Infant Health Committee—Judson L. Hawk, Jr., Atlanta; Education Committee—Louis S. Sullivan of Atlanta, Charles O. Walker of Donalsonville, Floyd E. Davis of East Point; Committee on Third Party Relations—J. Edward Dempsey of Athens.

Information on new developments can be freely exchanged in a smaller society, the author explains, and specialties can play an important role in educating the general medical community.

The Role of Specialty Societies in Continuing Education

H. RODNEY HARTMANN, M.D., *Savannah**

THE CONTINUING EDUCATION of medical specialists in this country has traditionally been a hodgepodge of refresher courses offered by both national and regional societies as well as university medical centers in combination with varying degrees of self study. The overall effectiveness of this form of laissez-faire approach to education is difficult to assess. It is clearly evident however, that a nightmare of uncoordinated and often repetitious programs did evolve and continue to evolve from this system. There seems to be little consideration for the educational needs of those attending refresher courses with the content of the programs often dictated by the availability of speakers or the special interests of the organizers. The attendance is often directly proportional to the location of the meeting rather than the educational content, with prime resort locations assured of success.

Quality Control Needed

The importance of quality control in medicine has become increasingly apparent through the years. The only way to maintain a high standard of care by medical specialists is to insure that there is a coordinated program in continuing education which is designed to meet the needs of the participants. The AMA has been instrumental in accrediting educational programs as a part of their Physicians Recognition Award. This has been an important step in quality control for medical education and now that several specialty boards plan to use accredited courses as a part of recertification, a whole new emphasis is being placed on the quality of continuing education, particularly in the way that it relates to patient care.

For many years the courses that have been offered by national specialty societies and large teaching centers, have grown enormously in size. National society meetings are often attended by thousands of registrants, which by necessity, limits the plan of educational presentations to didactic lectures with practically no opportunity for exchange between instructors and pupils. The material that is presented is often research oriented, or at least tailored to the type of practice that is carried on in an academic environment. Many of those attending, who are basically involved in clinical medicine in nonuniversity hospitals, find the course content of limited practical value.

The regional specialty society is an ideal vehicle to reach the practicing physician and provide him with the type of information he needs to deal with everyday problems, including the newer developments in the specialty. The size of such a society permits innovative learning formats with free exchange of information between instructors and pupils. Information can be kept basic while still providing a good mixture to stimulate more advanced members. Close geographic relationship permits meetings to be held frequently at relatively little expense to the participants. The smallness of the society also encourages informal telephone consults on patients and problems which are often one of the most effective means of continuing education.

General Medical Community

There is a whole new potential for the specialty societies which is most exciting. Recent advances in medical and surgical treatment of many diseases, including coronary atherosclerosis and the various syndromes of cerebral vascular insufficiency, to mention just a few, make prompt and appropriate referral of patients essential. Many diseases that were formally thought to be untreatable are now amenable to appropriate therapy, often on an emergent or

* President, Southeastern Angiographic Society and a member of Radiology Associates of Savannah, 5223 Paulsen St., Savannah, Ga. 31405.

semiemergent basis. The specialty societies, by providing speakers and panel discussions for both medical society and hospital staff meetings, can educate the general medical community as to what cases are now amenable to therapy and how emergent the referral is. They can also identify those centers in the referral area that have the capability to handle each type of problem, so that patients can be channeled to the proper institutions. The referring physicians can also be given some idea of what the expected results from the treatment may be, about how long it will take, and perhaps some idea as to the cost; all of which are important to the patient and his family. The Society of which I am president has recently established a speakers bureau for the purpose of disseminating this type of information, and this is one area where we feel specialty societies can contribute significantly to the continuing education of other physicians and the medical community in general.

In the future I see an expanded role for specialty societies in continuing education with the emphasis on quality programs utilizing formats designed to actively involve participants in the learning experience. There will be an intensified effort to identify specific needs and design programs to meet them. Larger societies will sponsor programs where attendance is limited to manageable proportions. Regional specialty societies have the opportunity to become the working liaison between the practicing physician and the educational resources available to him. They are in the enviable position of being able to relate closely to the clinical problems and personalities of an area, thus providing a very tangible contribution to the ultimate goal of quality patient care through continuing education. ■

HIGHLIGHTS OF COUNCIL
March 14, 1976

MAG FINANCES: Received a report of the Treasurer concerning the financial situation of the Association. It was announced that there is a projected deficit of $331,258.50 for the fiscal year 1976-1977. It was pointed out that there has not been a dues increase since 1970 and that all costs of operating the Association have escalated considerably during that time. The Treasurer reported that a dues increase of $90.35 per member in 1977 would balance the budget. This would mean that the dues might have to be increased again next year in order to keep up with rising costs due to inflation.

MEDICAID LAWSUIT UPDATE: MAG legal counsel filed a brief in opposition to consolidating MAG's suit with that of the Georgia State Medical Association. Judge Freeman considered the matter in December and consolidated the two cases. The backlog of cases kept the MAG suit from being formally assigned and delivered to Judge O'Kelley until early January. He did not formally review the case until late February. In the meantime, the Federal defendant filed a motion to dismiss the MAG suit. The Court has been urged on numerous occasions in the past three months to take prompt action and set a date for a hearing on the motion for a preliminary injunction. Judge O'Kelley is aware of the long delay and will schedule a hearing as soon as the calendar permits. MAG's legal counsel says the hearing should be scheduled for some time in April.

GMCF SELF-EVALUATION STUDY: Received a report that the Foundation Board had accepted the self-evaluation study. Council commended those who prepared the report for their efforts.

CANCER REGISTRY: Received a report that the Cancer Registry has been funded by the Department of Human Resources through June 30, 1977.

PRISON HEALTH COMMITTEE: Received a report that several law enforcement agencies in Georgia have been contacted and have agreed to participate in the pilot program.

UNNECESSARY SURGERY REPORT: Received a report from Harrison L. Rogers that he and Jack Menendez of Macon travelled to Washington, D.C., recently and talked with Congressman William S. Stuckey, a member of the subcommittee dealing with this report. At Congressman Stuckey's suggestion, MAG will draft a rebuttal to the report and submit it to the subcommittee.

MALPRACTICE LEGISLATION: Received a report that the General Assembly passed legislation dealing with the statute of limitations on malpractice suits which will greatly improve the current law. The ad damnum clause also was passed in the Legislature and will help spare physicians from adverse publicity. The arbitration bill is in a study committee of the House Judiciary Committee and will come out probably at the next session of the Legislature.

DRUG SUBSTITUTION: It was reported that a bill which would have permitted the pharmacists to substitute the cheapest brand unless the patient, not the doctor, instructed otherwise, failed to pass the legislature.

Legislative Roundup 1976

JAMES A. KAUFMANN, M.D., *Atlanta**

THE 1976 GEORGIA GENERAL Assembly ended its deliberations at 1:18 a.m., March 5. During the session, which began January 12, your Association took an active part in determining the outcome of 56 different bills. Some of these bills now are law, some were defeated and some were postponed.

This year, more so than in the past, many MAG members took an active role in contacting their legislators in support of the MAG position on specific bills. This is the only way for the physicians of Georgia to have a say in the laws passed by the Georgia legislature.

A Vital Service

A vital part of the public relations program MAG has with the legislature is through the Doctor-of-the-Day program in which a different Georgia physician donates his time each day to staff the medical aid stations for the legislators. Every year more legislators visit the station for their emergency health needs. The physicians who participated are to be commended for taking the time to come to the Capitol and assist in this most vital program.

The physicians who served as Doctor-of-the-Day this year were: James A. Kaufmann, Atlanta; Stephen May, Kennesaw; Robert S. Robinson, Metter; M. C. Adair, Rome; J. R. B. Hutchinson, Atlanta; Henry E. Steadman, Atlanta; Nelson McGhee, Atlanta; Mickey O'Connell, Waycross; Roland Summers, Savannah; Curtis Hames, Claxton; Robert Trent, Decatur; John Ellis, Dunwoody; Dean B. Talley, Carrollton; Buz Sawyer, Decatur; Howard Yager, Atlanta; Ernest Jones, Decatur; Dick Griffin, Cartersville; James Langford, Roswell; Donald Thomas, Dalton; Jack Menendez, Macon.

Lawrence Davis, Cartersville; Larry Freeman, Chamblee; Jimmy Burns, Gainesville; A. B. Dudley, Columbus; Bill Morton, Cairo; F. E. Gilliard, Douglas; George Green, Sparta; J. R. Arnall, Perry; James Baugh, Milledgeville; Thomas German, Savannah; Beverly Sanders, Macon; Tom Lumsden, Clarksville; Garland Kinard, Roseville; Dan Ward, Augusta; Dearing Nash, Savannah; Donald McKenzie, Thomasville; James Marlow, Dalton; Judson Hawk, Atlanta; G. A. Johnston, Macon; Bob Wight, Tifton; and James Dismukes, Adel.

Malpractice legislation was of primary concern to the MAG this year. We were successful in passing two significant laws which will have an effect on the premium you will pay in the years to come. Every MAG member, as well as every Georgia citizen, owes a great deal of gratitude to the following legislators for their help in passing S.B. 464 (Statute of Limitations) and H.B. 1446 (Removal of the Ad Damnum Clause). I *urge* every MAG member to write these gentlemen and thank them.

Lt. Governor Zell Miller
Sen. W. W. Fincher
P.O. Box 149, Chatsworth 30705
Sen. Ed Garrard
956 Plymouth Road, Atlanta 30306
Sen. Culver Kidd
P.O. Box 370, Milledgeville 31061
Sen. Paul Coverdell
1447 Peachtree St., Atlanta 30309

Rep. Roy Lambert
126 Washington St., Madison 30650
Rep. Wayne Snow
P.O. Box 26, Rossville 30741
Rep. Tom Taggart
139 Whitaker St., Savannah 31401
Rep. Larry Walker
P.O. Box 1234, Perry 31069
Rep. Bill Sams
410 First National Bank Building, Augusta 30902
Rep. Wash Larsen
P.O. Box 2002, Dublin 31021
Rep. Bill Lee
5325 Hillside Dr., Forest Park 30050
Rep. Crawford Ware
P.O. Box 305, Hogansville 30230
Rep. Wilbur Baugh, M.D.
Box 926, Gordon Road, Milledgeville 31061

Many others assisted in passing those bills, but these men took the lead and pushed it through. The

* Chairman of the State Legislative Committee. Dr. Kaufmann is an internist in practice at 950 West Peachtree St., N.W., Atlanta, Ga. 30309.

names of those legislators who led the fight *against* and voted against our position can be obtained through contacting Rusty Kidd at the MAG Headquarters Office.

Review of Specific Legislation

Following is a review of the primary legislation which was of concern to MAG this year.

S.B. 464 Malpractice—Statute of Limitations: Passed House and Senate; MAG strongly supported. This bill specifically states that all medical malpractice suits shall be filed within two years from the date of occurrence. This is the strongest statute of limitations in the country and quite an accomplishment.

H.B. 1446 Malpractice—Ad Damnum Clause: Passed House and Senate; MAG strongly supported. All medical malpractice suits filed in excess of $10,000 no dollar amount can be stated. In essence, this will prohibit the filing of a suit for $2 or $3 million, cutting down on the amount of publicity.

S.B. 465 Malpractice—Arbitration: Passed Senate; MAG supported. After S.B. 465 passed the Senate, a substitute version was presented to the House Judiciary Committee. This version is a very massive piece of legislation which will permit the signing of a voluntary binding arbitration agreement before and/or after treatment has been rendered. The Judiciary Committee thought it best to study this 33-page bill, perfect it and reintroduce it in 1977 seeking its passage then.

H.B. 1445 Malpractice—Report to Board of Medical Examiners: Passed House; MAG supported. This medical housekeeping bill was defeated by the Senate Judiciary Committee. H.B. 1445 simply stated that for all cases settled in court against a physician on a medical malpractice suit, the court would notify the Board of Medical Examiners of its decision. The Board is the licensing agency for physicians in Georgia, and if a physician has done wrong on several occasions, this agency should be notified.

H.B. 757 Health Maintenance Organizations: Passed House; MAG opposed. This permissive bill, to which MAG objected, has been placed in a study committee by the Senate Human Resources Committee. MAG's position on HMOs is that if a bill must pass, it should include certain points. H.B. 757 does not contain these points. An HMO bill may past the legislature in the near future.

H.B. 1618 Illegal Practice of Medicine—Felony: Passed House and Senate; MAG strongly supported. Current Georgia law states that if someone practices medicine without a license, it is a misdemeanor. H.B. 1618 changes it to a felony. The Board of Medical Examiners and local district attorneys agree with MAG that this was needed.

H.B. 1705 Generic Drug Substitution: Defeated by House Committee; MAG vigorously opposed. This extremely broad legislation would have required a pharmacist to substitute for any prescription the least expensive drug available. If this was not done the pharmacist would be fined $100. MAG felt this or any blanket drug substitution would remove the control of patient care from the physician.

H.B. 1750 Atlanta Blue Cross and Blue Shield Merger: Passed House and Senate. This bill, introduced late in the session, legally permitted the Atlanta Blue Cross and Blue Shield to merge, alter the makeup of the Board, permit establishment of HMOs and sell life insurance. MAG opposed the HMO aspect of this bill and had a number of questions about the remainder of H.B. 1750. Due to the lateness of the session and the urgency of the Insurance Commissioner, we opposed the HMO aspect, which was deleted, and took no position on the remainder of the bill.

H.B. 1756 Family Practice Advisory Board: Passed House and Senate; MAG strongly supported. This bill, supported by the Georgia Academy of Family Physicians, will create a Family Practice Advisory Board to assist in the regulation of family practice residency program throughout Georgia. Hopefully, when funds become available, this Board can help channel money to the Medical College of Georgia's Department of Family Practice to produce more family physicians for the state.

H.B. 1907 Radiation Control Act: Passed House and Senate. The original version of this bill would have put control of *all* radioactive materials under the supervision of the Environmental Protection Agency Division of the Department of Natural Resources. Currently control of radiation useage by physicians offices and hospitals comes under the Department of Human Resources. The Georgia Radiological Society was opposed to this transfer of authority and along with MAG was successful in keeping control of all medical useage of radiation under DHR while all other radioactive useage will be under the control of the Department of Natural Resources.

H.B. 88 Optometry: Amended version passed House and Senate; MAG vigorously opposed. MAG has been plagued by this bill for a number of years. The original version states, "it shall be unlawful for any State board, body, agency of State government, public official or state institution to discriminate against an optometrist or a physician in the recommendation of visual care." There was a penalty section permitting injunctive relief, a section permitting physicians to recommend whomever they wanted and a section permitting those with custodial care to recommend whomever they desired. The injunctive relief section was deleted which made H.B.

88 less offensive. This bill was and still is vague and leaves for determination what constitutes discrimination. Hopefully, the Governor will veto H.B. 88.

S.B. 437 Clinical Laboratories: Amended version passed House and Senate. The original version would have exempted all DHR, U.S. government and the Medical College of Georgia laboratories from conformance with the clinical laboratory rules and regulations promulgated by the Department of Human Resources. This version MAG opposed. The final version, on which MAG took no position, removed from the current Clinical Laboratory Act all labs at the MCG, Emory Medical School and any other medical school in Georgia.

S.B. 603 Emergency Medical Technicians: Passed Senate; MAG supported. This bill provides for certification of all EMT personnel. This certification will be regulated by the Board of Medical Examiners. Hopefully, under this Act, all EMT's will be better trained and will be of more assistance to those in need.

S.B. 633 Telephone Answering Service: Passed Senate; MAG supported. This bill was designed to ease potentially difficult situations when the telephone company found it necessary to terminate services to an answering service which had physicians and dentists as its clients. The telephone company is required to notify the answering service and the Public Service Commission by registered mail at least 10 days prior to the termination of service. S.B. 633 made it a misdemeanor if the answering service did not notify its subscribers before the service was terminated and would make the service liable for any damages arising if their subscribers had not been notified. This bill passed the Senate and House committee but was not called for a vote on the final day. We will try again next year.

S.B. 694 Abortion: Failed in committee, MAG opposed. This entire rewrite of Georgia's abortion law was defeated in the Senate Judiciary Committee.

Board of Medical Examiners Appropriation: Passed House and Senate; MAG strongly supported. The Composite State Board of Medical Examiners was in dire need of additional funds to hire investigators, etc. Working closely with the Board, we were successful in obtaining $155,000 more in appropriations for the Board than last year.

H.B. 2084 Drivers License—Physicians Reporting: This bill had the concurrence of the Department of Public Safety. Unfortunately, it was introduced late in the session, and time alone defeated it. This bill would have changed current law which states physicians *"shall* report to the Department of Public Safety" to *"may* report" those patients 15 years of age and older who have a disability which may limit their ability to drive an automobile safely.

Political Involvement

1976 is an election year. In order for MAG to continue to have a successful legislative program, more physicians have to become more active in the political arena. Currently there is only one Georgia physician in the legislature, Wilbur Baugh, M.D. of Milledgeville. It would be wonderful if more of you could and would get interested in running for office.

Those of you who do not want to run for public office should take a very active part in assisting your legislator or his opponent in getting elected this fall. This assistance comes in various forms. Financial support always is desired. Verbal support from you or your family and friends is needed. You can offer the assistance of your secretary occasionally to write letters or make telephone calls—also a necessary part of any successful campaign.

There are other ways to participate in a campaign. Hopefully you will contact me or Rusty Kidd for these additional ideas and become active, helping reelect our friends and defeat our foes. ■

(Ed. note: A little-known statute has gone into effect in Georgia which requires the reporting of health and vision information about patients to the Drivers License Advisory Board of the Department of Public Safety. Physicians and optometrists are to do the reporting on all patients over 15 years of age within 10 days of diagnosis of any problem that might prevent the patient from operating a motor vehicle safely. The license of such patients then might be suspended or revoked.

The statute and guidelines, explained in a letter to Georgia physicians in January and February, rapidly has become controversial. The concerns raised are for the confidentiality of the doctor-patient relationship and potential liability of a physician for future accidents his patients might be involved in if he fails to report all conditions that could affect ability to drive.

In order to explore the subject, we have asked Lawrence Freeman, M.D. of Chamblee to explain his objections to the law in the editorial below. Fleming Jolley, M.D. has written his first President's Letter on the subject, too. As chairman of the Drivers License Advisory Board, he defends the need for the law. Finally, on the Legal Page we have provided a lawyer's view of the weaknesses of the statute and advice on how to cope with them.)

Should Physicians Be the Watchdogs of Society?

THERE ARE MANY objectionable features of Georgia Code Section 68B-217, but by far and away the most serious is the disastrous effect it would have on the confidentiality of the doctor-patient relationship. We as physicians, parents, and citizens do have a responsibility to do what we can to reduce, where possible, the hazards of the road. However, our foremost responsibility always must be the welfare of our patients. Any loss of confidentiality can only operate to the ultimate harm of the patient public.

This law places the physicians in the impossible position of being a policeman. It was written by law enforcement officers who are accustomed to operating with the force of law and a gun backing them up, but we physicians are less rigid authoritarian figures and we must accomplish our goals by education, reason, and psychological persuasion. We are not, cannot be, should not be, and our patients do not want us to be the Watchdogs of Society.

Responsibility Belongs Elsewhere

In discussing this with a member of the House Motor Vehicle Committee where the wording of the law originally was written, I suggested that if society wants to identify all potential drivers who may have any of these disorders or disabilities, then have each person at the time he renews his drivers license fill out a health questionaire which could be as broad as the Department saw fit. There could be severe penalties for falsely concealing any such condition. This method would be much simpler and would place the responsibility where it belongs—on the driver and the public, not on the physician.

He said that a similar proposal had been made, but it was never considered seriously by the committee because, "the public would not accept this." If anyone should be Watchdogs of Society it is the legislators and if they are not willing to accept this responsibility, it is the height of absurdity that they

should expect us physicians to do it.

As it is written, the law would be impossible to administer. The physicians in the state do not have the time to fill out this form on every patient who has any of the listed conditions. The Department does not have the resources to receive and file the thousands of reports which would come in every week, nor the personnel to investigate even a small percentage of them. We have been told by Dr. Fleming Jolley and the Department of Public Safety that we do not have to report every person with any of these conditions and that, "only the medical impairments which are uncontrolled under the physician's management resulting in loss of conscious control of one's self and mechanically impaired individuals in coordinated (sic) control of one's self should be reported."

This is not very reassuring when the law states, "*all* physicians . . . *shall* report . . . *every* person over 15 years of age diagnosed as having *any* such specified disorder or disability within 10 days." . . . To decide by general consensus that although a law states very clearly one thing it should be interpreted another way puts us on very questionable legal footing and is an exceedingly dangerous precedent. Society might very well decide to change any law by consensus rather than go through the tedious legislative process.

We also have been told that there is nothing the state can do to a doctor who does not obey the law. Any such law is not only useless, it is ridiculous. However, the medico-legal dangers are obvious. Suppose a patient of mine who has hypertension has an automobile accident and I have not reported him to the Department as required by the law. The victims may insist on my civil, if not criminal, liability. The patient himself might sue me for not having reported him.

Magnitude of Problem Question

I also question seriously the magnitude of the problem. I asked the head of the Driver's License Division how many accidents the Department could document in the last 10 years in which the cause could have been related to a previously diagnosed condition covered by these guidelines. He replied that he did not know, but if one accident occurred it was too many. This, of course, is an emotionally appealing response, but I need to know if the benefit to society would be enough to justify the cost—my time, my patients loss of privacy, my increased liability risk, etc.

Even the Department of Public Safety must realize that cost factors influence their life saving capabilities. Every time another patrol car is added to the highway force the death toll from automobile accidents is appreciably reduced. Yet there is a finite limit in the amount the state is willing to pay for additional patrol cars and men to man them.

We all know that alcohol is an infinitely greater hazard on the highways and is responsible for accidents many times those due to all those caused by the listed health problems combined. If the Department would like to reduce the carnage on the highway by a large amount then we should require that every bartender and every liquor store salesman report the name, address and Social Security number of every person purchasing alcoholic beverages. This information could be run through the computer thereby identifying the problem drinker and steps taken to remove his driver's license. This would be only slightly more difficult to administer and should be just about as acceptable to the drinking public as this law will be to the patient public.

Changes Proposed

Because of a position taken by the Executive Committee of MAG approving the present law, the Department introduced into the just-concluded General

Assembly a bill to amend the law. Due to the lack of time, no action was taken on this, but we have been assured that it will be brought up next year. It would strike in its entirety subsection (b) (which I quoted above in an abridged form) and would substitute a new subsection as follows:

"(b) All physicians licensed under Georgia Code Chapter 84-9 to diagnose and treat disorders and disabilities defined by the Department *may* report to the Department the full name, date of birth and address of any person with a handicap which would render such a person incapable of operating a motor vehicle safely."

The substitution of the word "may" for "shall" certainly would make the law more acceptable, but it would also make it meaningless. I feel that singling out physicians as the prime reporter under the law is still unacceptable since it continues to place us in a difficult position ethically and morally. I propose even broader changes.

The title of Section 68B-217 be changed to "Reporting of Potentially Hazardous Drivers." Subsection (a) be rewritten to state, "(a) The Driver License Advisory Board appointed by the Department shall define disorders or disabilities affecting the ability of a person to drive safely for the purpose of forming general guidelines for the use of the Department in identifying such disorders and disabilities which could prove to be disqualifications, under certain conditions, for obtaining or keeping a driver's license for any class or classes of vehicles."

Subsections (b) and (c) would be stricken in their entirety and a new subsection (b) substituted as follows:

"(b) All persons shall be requested and encouraged to report to the Department any persons with a condition which could render such person incapable of operating a motor vehicle safely."

Subsection (d) would become subsection (c) and should be reworded to state "(c) The reports obtained by this section shall be confidential and shall be used solely for the purpose of determining the qualifications of any person to drive a motor vehicle on the highways of their state. No civil or criminal action may be brought against any person or agency for providing the information herein required or requested. This protection shall be interpreted to include instances where the question of confidentiality or privilege might be raised. The reports, or any reference to the reports, shall not be included in any abstract prepared pursuant to section 68B-215 of this Title."

Subsection (e) would become subsection (d). The procedures for handling those cases reported to the Department would be essentially the same as outlined in the Rules of the Department 570-17-.09.

This not only would allow the physician to report any patient when in his judgment it was in the best interest of his patient and society, but would also allow the bartender to report the problem drinker, and anyone else to report the incompetent or incapacitated driver be he relative, neighbor, or business associate.

Lawrence L. Freeman, M.D.
3652 Chamblee-Dunwoody Road
Chamblee, Georgia 30341

president's letter

Physicians Can Help Reduce Death and Injury on the Highways



A LAW HAS BUT ONE REASON to exist. Arguments against the law obviously outnumber its single purpose. Despite such arguments, the need for the law's existence is not negated. Is the right of an individual versus the privilege of an individual a debatable issue?

Organized medicine has for many years denounced mandatory reporting of medical handicaps for the same reasons as reported on the Editorial Page of this *Journal*. The American Medical Association has reaffirmed such a position.

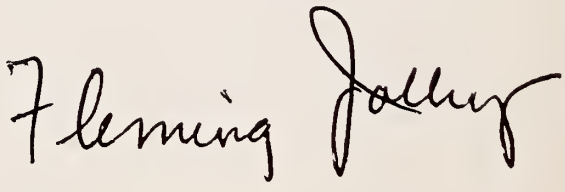
Documented statistics by various investigators demonstrate a significant variance in the incidence of motor vehicular collisions with certain medical handicaps. Driver error far exceeds the highway environment or faulty vehicles in the cause of morbidity and mortality.

The actual reduction in death and injury on the highway experienced in the past two years has resulted from a multidisciplinary approach. The reduction in speed, decrease in usage of alcohol behind the wheel, improvements in vehicular safety, and education of drivers (each of which has been enhanced through laws of the land), have attracted the individual's responsibility.

States have recognized the need for advisory boards in determining adverse handicaps for the privilege of operating vehicles. The success of such boards has varied to the extent of support from all sectors. Florida, Pennsylvania, Oregon and Kentucky led the initial efforts; hence have had a longer track record.

Georgia's Drivers License Advisory Board is now three years old. It was created by the Governor and constitutionally approved by the 1975 General Assembly. The Board is administered through the Department of Public Safety as are the regulations by which the Board functions. These regulations have been adopted from the experiences in other states as time proved their value in various modifications.

Responsible people have sought the help of individuals whom they consider the most knowledgeable—the doctors. Would there be such a law if an otherwise effective system existed? Certainly, the word "mandatory" is offensive. Is shifting the responsibility the answer to this underlying problem?



Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Lumps and Bumps—Neck

JOEL P. SMITH, JR., M.D., *Atlanta**

NECK LUMPS can be the nemesis of many diagnosticians and clinicians because late or incorrect diagnosis ultimately is detrimental to the patient's outcome. The seriousness of this situation is reason enough to re-emphasize the simple and basic approaches one should take in handling these situations.

Beginning with the lump, an inflammatory node is usually tender and soft as opposed to rock hard. A very hard node is usually malignant. A branchial cleft cyst, Zenker's diverticulum, or laryngocele is a possibility if the mass is located on the anterior border of the sternocleidomastoideous muscle anatomically, especially if fluctuant. If a midline lesion is encountered, the presence of a thyroglossal duct cyst or inclusion cyst should be considered. Usually it is helpful to localize the lump in the anterior or posterior cervical triangle, thus affirming its relationship to the sternocleidomastoid muscle. Tumors from the chest and abdomen may present in the supraclavicular fossa, which is considered a part of the posterior cervical triangle. Metastatic cancer from the head and neck usually occurs in the anterior triangle.

Single or Multiple

Another meaningful observation is the determination as to whether the lump is single or multiple. Matted or multiple lumps direct one's thinking more to infectious processes, even cervical tuberculosis, or one of the lymphomatous processes. Statistically, solitary lumps are more often metastatic in origin.

Since a neck lump is the first and only sign in over 50 per cent of the nasopharyngeal cancers and over 30 per cent in cancer of the tongue, tonsil, and thyroid, a thorough search for "the primary" will often reveal the diagnosis. Difficulty in swallowing, coughing up blood, hoarseness, nasal congestion, with or without bleeding, and any sores around the mouth area should be investigated. Examine closely the tongue, gums, mouth, tonsil area, nasopharynx, hypopharynx and larynx. Palpation of these areas can be done relatively easily, but still most important is visualization after topical shrinking of the nasal turbinates and a topical anesthetic to the pharynx. External palpation of the neck should be done to anatomically localize the lump, determine its physical characteristics, and associate its relationship to normal glands such as the thyroid. Also, inspection of the scalp, especially temporal skin, should be done, since melanoma may well present itself as a mass in the neck.

Any complaint from a patient regarding the "special senses" with a neck lump should require strict attention. Decreased hearing in one ear is a valid complaint, since unilateral serous otitis media in an adult is considered to be nasopharyngeal cancer until proven otherwise. Visual disturbances, especially diplopia, should be investigated. Taste changes, tongue mobility or pain to one side of the head, which

* Doctors Memorial Hospital, 20 Linden Ave., N.E., Atlanta, Ga. 30308. Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

may be referred from those critical areas (tongue, tonsil, larynx and thyroid), need explaining.

Confining ourselves still to the basics, X-rays under consideration would include a study of the sinuses and chest followed by a barium swallow, laryngogram and possibly a thyroid scan. All suspicious areas, except the neck lump, after palpating, should be biopsied first even if general anesthesia is required. If random biopsies are indicated, be sure to include Rosenmullers fossa in the nasopharynx and the base of the tongue. Endoscopy should be performed at the same time.

For many reasons, a biopsy of the neck lump should be delayed as a last resort. These reasons range from seeding cancer cells to lessening the effectiveness of radiation where it is most needed and where it may be the primary treatment. If no primary is found, then by all means, the neck mass must be biopsied; but frozen section, followed by a more radical procedure, should be anticipated at the same time.

In conclusion, it is worth remembering that a firm, unilateral lump in an adult will run about 70 per cent metastatic cancer and about 20 per cent congenital anomaly, with the remaining 10 per cent related to inflammatory processes. Of the metastatic nodes, about 70 per cent of these will have their primary in the head and neck area, while the remaining 30 per cent will be from the skin of the head and neck, from other distant viscera, and even a few primaries may be undetermined, requiring a re-examination of the nasopharynx, the base of the tongue and the thyroid.

Needless to say, establishing the correct diagnosis not only as to tumor type, but also anatomical location, would delineate a better management program that could be coordinated with the many disciplines who treat this area. But the most benefit would go to the patient with the neck lump. ■

GEORGIA PHYSICIANS EARN DIPLOMATE STATUS

Several Georgia physicians have been named new Diplomates of the American Board of Family Practice. Those named passed a two-day written examination in the areas of internal medicine, surgery, obstetrics, gynecology, pediatrics, psychiatry and community medicine. To qualify for the examination, they must have completed either a three-year family practice residency or been in family practice at least six years, successfully completing 300 hours of continuing medical education approved by the American Academy of Family Physicians. They are recertified every six years if they continue to show competency.

The new Diplomates from Georgia are: Benjamin S. Anderson, Jr., Cedartown; Malcolm P. Dulock, Norcross; John M. Fillingim, Savannah; William A. Hitt, St. Simons; Hugh O. Hodges, Winder; Ronald M. Hudson, Columbus; George R. Jones, Chamblee; Ferdinand Vogt Kay, Macon; Edwin Aylette Mayo, Brunswick; Earl Taylor McGhee, Dalton; William Smith Miller, Dalton; William Joseph Morton, Cairo; B. Lamar Murray, Waynesboro; Franklin E. Payne, Jr., Augusta; Morgan N. Whaley, Thomson; and Charles E. Wills, Jr., Washington.

The Innocent Heart Murmur

RICHARD A. BARDACK, M.D. *and* BARRY D. SILVERMAN, M.D., *Atlanta**

THE INNOCENT MURMUR is a murmur which is not associated with anatomic or physiological abnormalities of the heart. It is important to separate these murmurs from those associated with organic heart disease. There are several characteristics of innocent murmurs which help in their separation. First, innocent murmurs are generally systolic. They may occasionally be continuous but are never purely diastolic. They are rarely louder than a grade 2-3/6, vary with the position of the patient, often disappear with inspiration, and tend not to radiate. The systolic innocent murmurs are grouped as follows: 1) the vibrating systolic murmur (Still's murmur); 2) the pulmonic systolic murmur; 3) the supraclavicular systolic murmur; and 4) the aortic systolic murmur.

The vibrating systolic murmur or Still's murmur is frequently seen in the age range of three to seven years. It is typically a 2/6 short, early systolic murmur heard along the left sternal border in the third to fourth intercostal space. The murmur is classically described as a twanging of a tuning fork or a vibratory buzzing quality. *The pulmonic systolic murmur* is best heard in the second left intercostal space. It is a brief, high-pitched blowing murmur, grade 1-3/6 and is best heard in the supine position. This murmur may be accentuated by exercise, fever, or excitement. The murmur frequently increases with expiration. This murmur is felt to rise from the pulmonary trunk during normal ejection and is louder in a person with a thin chest wall. *The supraclavicular systolic murmur* is best heard above the clavicle, usually louder on the right than on the left. A thrill is frequently present, which radiates into the neck and occasionally below the clavicle. The murmur is crescendo-decrescendo in shape and may decrease with partial compression of the artery above the clavicle. Hyperextending the shoulders will also diminish the murmur. *The aortic systolic murmur* is a murmur frequently heard in adults over the age of 50. The murmur does not truly fit the definition of an innocent murmur in that it is associated with sclerosis of the aortic leaflets. It is early to midsystolic, usually short and not associated with an ejection click. It can be heard in the neck but does not radiate widely.

Continuous Innocent Murmurs

There are two types of innocent murmurs which can be described as continuous. These are the venous hum and the mammary souffle.

The venous hum is almost universal in children and can frequently be heard in healthy adults. It is best heard in the supraclavicular fossa, usually louder on the right than on the left, but may be present on both sides. The murmur can be abolished by digital compression and increased by tilting the chin upward and away

* Dr. Bardack is an Emory University cardiac fellow, supported by grant from Northside Hospital; Dr. Silverman is an Emory-Northside assistant professor of medicine, 1000 Johnson Ferry Road, N.E., Atlanta, Ga. 30342.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

from the supraclavicular fossa being examined. The intensity of the murmur changes considerably with rotation of the head. *The mammary souffle* is a continuous murmur which may be heard along the left sternal border in pregnancy or in lactating women. It is best heard with the patient supine and may disappear in the sitting position. It is not affected by the Valsalva maneuver and light pressure with a stethoscope tends to augment the sound. This murmur is distinguished from a murmur of patent ductus arteriosus which peaks at the second sound, whereas the mammary souffle peaks early in systole.

Evaluation of these murmurs is frequently a puzzling problem. There are several techniques of examination which we have found useful in assessing these murmurs. Innocent murmurs are associated with normal precordial palpation and a normal apical impulse. The heart sounds are of normal intensity with normal splitting of the second heart sound. These murmurs are short, generally soft, rarely greater than a grade 3/6, do not radiate widely, and are not associated with thrills, except the supraclavicular systolic murmur.

Complete evaluation of the murmur requires a chest x-ray and electrocardiogram. The chest configuration on physical and with x-ray will elicit those conditions which can mimic heart disease, specifically the straight back syndrome and chest deformities such as the pectus excavatum.

In conclusion, it is important to establish the diagnosis of an innocent murmur. A heart murmur is often a frightening and discomforting finding and may cause unnecessary concern among patients and parents. Careful evaluation of patients with heart murmurs can avoid mislabeling normal patients as having heart disease. ■

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MAY CONFERENCES ON HEART DISEASE INVOLVE MAG MEMBERS

Cardiology Conferences for Health Professionals will be presented in May by the Georgia Heart Association in Albany, Atlanta, Augusta, Columbus, Rome and Savannah.

Nurses and other health professionals from throughout the state attend the conferences each year to learn about new advances in the prevention and treatment of heart disease. GHA's nursing education committee coordinates the conferences, which are presented as part of the on-going professional education program of the Heart Association.

The conference in Albany will be Wednesday, May 26 at the Downtowner Motor Inn. Program participants include MAG members Chappell A. Collins, Jr. and F. Dempsey Guillebeau.

In Atlanta, the conference will be Thursday and Friday, May 27-28 at Georgia Baptist Hospital. The faculty includes William Maloy.

The Augusta conference on Thursday and Friday, May 27-28 at University Hospital will feature Harry T. Harper, Jr., Paul E. Cundey, Jr., David W. Cundey, and Harry T. Harper, III.

Columbus area health professionals will attend on Thursday and Friday, May 20-21 at Columbus College. The college's health science division is co-sponsoring the conference with the Muscogee County Heart Unit. Program participants are Howard Vigrass, Jack Blalock, Robert Patton, Gordon Miller, Norman I. Goldman, George Armstrong, and C. Daniel Cabaniss.

Rome's conference will be Friday, May 28 on the Berry College campus.

In Savannah, the conference will be Thursday, May 27 at Memorial Medical Center, featuring Fenwick T. Nichols, Jr. and Joseph V. Morrison, Jr.

Registration information is available from the county Heart Unit office in each of the six cities or from the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, GA 30324.

Reporting Medically Impaired Drivers

STEPHEN J. ZOUKIS, *Atlanta**

In 1975, the Georgia General Assembly passed an Act adding Section 68B-217 to the Georgia Code. The Statute, which became effective on January 1, 1976, requires physicians and optometrists to report to the Department of Public Safety the name of every person over 15 years of age diagnosed as having a disorder characterized by a lapse of consciousness or other mental or physical disability. The only disorders and disabilities which must be reported are those defined by the Drivers License Advisory Board appointed by the Department as affecting the person's ability to drive safely. The Department of Public Safety has the power to revoke or restrict the license privileges of a driver suffering from incapacities which impair his ability to operate a motor vehicle.

Besides placing on the physician and optometrist the awkward duty of carrying tales to the Department of Public Safety, Section 68B-217 also raises questions concerning the ethics of such disclosure and a doctor's civil liability to the victims of automobile accidents caused by a disability or disorder which the physician failed to report.

Section 68B-217 provides that the Board shall ". . . define disorders characterized by lapses of consciousness or other mental or physical disabilities affecting the ability of the person to drive safely. . . ." Physicians and optometrists shall ". . . report to the Department [of Public Safety] in writing, the full name, date of birth and address of every person over 15 years of age diagnosed as having any such specified disorder or disability within 10 days after such diagnosis."

Effect of Regulations Unclear

The Board has promulgated certain regulations published in the Rules and Regulations of the State of Georgia at Section 570-17, but we cannot certainly state their effect on the reporting requirement since the purpose of the regulations is not entirely clear. They set standards which the Board must follow in determining whether to recommend that the Department revoke or restrict a driver's license because of some incapacity. It seems likely that the Board also intended these regulations to define disorders and disabilities which physicians and optometrists are required to report since the Department of Public Safety recently mailed a pamphlet containing both the Statute and the Regulations to all Georgia physicians and optometrists. The published Regulations, however, state specifically only that their purpose ". . . is to establish general guidelines for the Drivers License Advisory Board and to set Departmental procedures to be followed in determining whether to recommend the issuance of revocation of drivers licenses to functionally incapacitated persons." Despite the confusion over the effect of the Regulations,

* Prepared at the request of The Medical Association of Georgia. Mr. Zoukis is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Council to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

each physician and optometrist should carefully read the pamphlet in order to acquaint himself with the sort of disorders or disabilities which are covered.

The 1976 Session of the General Assembly rejected an amendment to Section 68B-217 which would have provided that physicians and optometrists ". . . may use their professional skill and judgment to determine if such disability or disorder would render such person incapable of operating a motor vehicle safely." The amendment was intended to give a physician or optometrist discretion to withhold reports from the Department if he believed his patient's disability or disorder would not make him unable to safely operate a motor vehicle.

If an amendment is again considered, it should contain a provision expressly relieving the physician or optometrist from the duty to report his diagnoses to the Department if, in his professional judgment, his patient is able to drive safely. The defeated amendment merely allowed the exercise of professional judgment, but provided no exemption from the reporting requirement even if professional judgment indicated the patient could drive safely. Consequently, it would have had little effect even if passed. Hopefully, an effective exemption ultimately will be created.

Ethics and Civil Liability

Two interesting questions concerning Section 68B-217 should be mentioned in concluding. One relates to the ethics of disclosing a diagnosis when such disclosure might damage the patient and the other relates to the civil liability of doctors who fail to make the required report.

Is it ethical for a physician to disclose his patient's disabilities to the Department of Public Safety when doing so may harm him? Section 9 of the Principles of Medical Ethics of the American Medical Association specifically provides that a physician may reveal confidences entrusted to him if he is required to do so by law or if disclosure is necessary to protect the welfare of the community. Although making these reports may disturb a physician when doing so might cause the Department to revoke his patient's driving privilege, Section 9 specifically addresses the question of confidentiality as it relates to reports required by law and it appears that the physician may make the required report to the Department.

Is a physician or optometrist liable to an automobile accident victim in the event of an automobile accident caused by a disability or disorder which the physician or optometrist failed to report? While Section 68B-217 does not create such liability, neither does the Statute protect against it. Such liability might be based upon the theory of cause and effect, that is to say, because the physician failed to make the required report, he permitted an unsafe driver to operate a motor vehicle on the State's highways and thus caused an accident. We cannot predict whether Georgia courts will accept such a theory in this area, but in an analagous situation it has been held that a doctor is liable to persons harmed as a result of his failure to warn them of the danger from a contagious disease which afflicts his patient.

Physicians and optometrists should be aware of their duty to make the required reports and alert to the possible consequences of failing to do so. ■

I've told this before

(Ed. note: A "grateful" patient shows his appreciation in this story by Carl Jelenko, M.D. of the Medical College of Georgia. Other contributions are solicited and should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

The Tapeworm Caper

ONCE UPON A TIME, in the dim and distant past, when I was serving my clerkship in medicine, I admitted a young, handsome, muscular sailor from Puerto Rico who harbored a tapeworm. He had been treated for this affliction several time previously with no results.

I studied and cogitated, and finally settled upon a regimen of therapy to which the patient was amenable.

I purged him with castor oil and placed him "NPO" overnight. In the morning I gave him the recommended dose of Atabrine. After a little while, I gave him the recommended dose of Oleoresin of Aspidium. After still another wait, I gave him a breakfast of raw sauerkraut. I then gave him another purging dose of castor oil.

The poor man writhed and strained. He produced four washbasins-full of material—but this *did* contain the scolexes of his two tapeworms! It took him three days to regain his full strength after this somewhat vigorous internal massage.

Some weeks after his discharge, the patient returned to the hospital and looked me up. He thanked me profusely for ridding him of his disability and in thanks and friendship gave me a bottle of "Puerto Rican Liquor" which he had "imported just for you."

I shook his hand and smilingly took a large swig of the somewhat-bland smelling material. It had an oily tangy taste. After 20 minutes, I began to get griping cramps in my mid-section. . . .

Carl Jelenko, III, M.D.
Professor of Surgery
Director, Burn Investigation Laboratories
Medical College of Georgia
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the association
the association
the association

NEW MEMBERS

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Yaghami, Farivar, Richmond—Act—Path
MCG, Augusta 30902

SOCIETIES

The March meeting of the **Bibb County Medical Society** included a report on the American Medical Association Leadership Conference given by Jack F. Menendez and Hugh F. Smisson, who attended. Increased membership of the society has meant its eligibility for an additional delegate to the MAG House of Delegates. John A. Wells, M.D. was chosen for the position.

The **Georgia Medical Society** heard from J. Roy Rowland, M.D. of Dublin at their March meeting. Dr. Rowland is the founder and chairman of the Committee on National Trends, Ramifications and Origins of Legislation, Inc. (CONTROL). His subject was "The Effect of Medical Legislation on the Political and Economic Structure of Our Society."

Hundreds of physicians throughout the state attended the **Medical Association of Atlanta's** Graduate Medical Assembly in mid-March at the Omni International Hotel. The Society plans a dinner meeting April 22 with Senator Sam Nunn (D-Ga.) as the featured speaker.

PERSONALS

First District

Mason G. Robertson, Savannah, has been certified as a Diplomate in the sub-specialty of medical oncology by the American Board of Internal Medicine.

Fourth District

Ted C. Moseley of Decatur has won the 1975 Julius McCurdy Citizenship Award given by the Decatur Federal Savings and Loan Association. The award was es-



Ted C. Moseley, M.D. (R) receives the 1975 Julius McCurdy Citizenship Award from Decatur Federal President J. Robin Harris.

tablished in 1973 to recognize outstanding members of the medical profession for their contributions to the community. Dr. Moseley was cited for conducting classes for high school girls during the past five years in cooperation with the American Cancer Society. He also has organized and coordinated sex education classes in county high schools in a cooperative program conducted by the Decatur/DeKalb YMCA and the DeKalb County Medical Society.

Fifth District

Emory University School of Medicine honored two of its alumni March 16 as part of "Dean Richardson Appreciation Night." Awards of Honor were given to **Richard W. Blumberg,** professor and chairman of the Department of Pediatrics, and Wadley R. Glenn, medical director of Emory's Crawford W. Long Hospital.

Two East Point physicians have been inducted as Fellows of the American Academy of Orthopaedic Surgeons. They are **Henry J. Bienert, Jr.** and **Alvaro Lievano.**

Milton Frank, Atlanta, has been elected a Fellow of the American College of Physicians and been promoted to assistant clinical professor of Medicine at Emory.

Seventh District

Rome physician **Edwardo Montana** helped coordinate relief efforts in Georgia for victims of the Guatemala earthquakes.

Eldon E. Hoose has begun practice at the Doctors Clinic in LaFayette after working for Hamilton Memorial Hospital in Dalton as an emergency room physician.

Eighth District

Brunswick surgeon **Charlton Futch** has been appointed medical director of a seven-county area by the Department of Human Resources, with the responsibility of promoting the development of emergency medical services.

Tenth District

James L. Becton of Savannah has been named chief of staff at St. Joseph Hospital, succeeding C. Stephen Mulherin.

Family physician **James P. Bannister** has opened an office in Madison. The Cumming native was graduated from the Medical College of Georgia.

Several Medical College of Georgia staff members have been appointed to the health advisory committee of the Georgia Association of Paraplegics, including **Marshall B. Allen** and **J. M. Still, Jr.**

Carl Jelenko has received a $50,000 HEW grant for the study of "Biomedical Effects of Burning of Skin."

Betty B. Wray, Augusta, has been certified as a Diplomate of the American Board of Allergy and Immunology.

DEATHS

Richard M. Brown, Joseph T. DeFoor and Robert C. Robbins

Three Marietta physicians, Richard M. Brown, 38, Joseph T. DeFoor, 38, and Robert C. Robbins, 43, were killed in a single-engine plane crash at McCollum Airport in Cobb County February 12. All were on the staff of Kennestone Hospital.

A memorial scholarship fund for the three physicians has been set up by the Cobb County Medical Society and Kennesaw Junior College. The fund will be used in the future to honor the memory of any member of the Cobb Society.

Dr. Brown, an ophthalmologist, was born in New York City and received his medical degree from Columbia University. He served a rotating internship at Jefferson Davis Hospital in Houston, Texas and residencies at San Francisco General Hospital and Barnes Hospital in St. Louis, Missouri. He was a veteran of the U.S. Air Force and belonged to the First Presbyterian Church in Marietta.

Dr. Brown is survived by his widow, Mrs. Ruth Nielsen Brown; sons, Richard M., Jr., Steven H. and Gregory C. Brown; parents, Mr. and Mrs. Charles H. Brown of Boca Raton, Fla.; sister, Miss Linda Brown, New York City.

Dr. DeFoor was an anesthesiologist trained at the Medical College of Georgia. His internship was served at Floyd Hospital in Rome with a residency in anesthesiology at the Medical College of Georgia, interrupted for two years by service in the U.S. Army. Dr. DeFoor was a member of the First Baptist Church of Decatur.

Survivors include his widow, Mrs. Harriet S. Hall DeFoor; daughters, Dee, Margaret, Susan and Mary Katherine DeFoor; son, Joseph T. DeFoor, III; parents, Mr. and Mrs. Joseph T. DeFoor of Decatur; brother, The Rev. William R. DeFoor of Tucker.

Dr. Robbins was born in Florence, Alabama and graduated from Emory University School of Medicine. His internship and residency in internal medicine were served at Emory-V.A. Hospital and Grady. Dr. Robbins served in the U.S. Army.

Pierpont F. Brown, Jr.

Gainesville physician Pierpont F. Brown, Jr., 55, died March 8. The Emory graduate served a rotating internship at Kings County Hospital in Brooklyn, N.Y. and a residency at the Atlanta V.A. Hospital. He was a former president of the Hall County Medical Society and served on the hospital authority and housing authority. Dr. Brown was a member of the board of trustees of the Gainesville Junior College Foundation.

Survivors include his widow, Mrs. Marilyn Woodberry Brown; daughters, Mrs. Cathy Brown Wilson and

Margie Brown; sons, Cleveland Woodberry Brown and P. F. Brown, III; mother, Mrs. P. F. Brown; and sister, Miss Frances Brown, all of Gainesville.

Wilson Taft Edenfield

Wilson Taft Edenfield, 48, chief of the radiology department at Georgia Baptist Hospital in Atlanta, died March 6. He was a graduate of the Medical College of Georgia, serving his internship and residency at Georgia Baptist, V.A. Hospital in Atlanta and Grady Memorial Hospital. He was a member of the U.S. Army Medical Corps two years.

Dr. Edenfield was a member of the Georgia and Atlanta Radiological societies, American College of Radiology and Radiological Society of North America. He was an honorary member of Sigma Pi Sigma.

Dr. Edenfield is survived by his widow, Mrs. Barbara Plaatje Edenfield; sons, Gary, Robin and Keith Edenfield of Atlanta; mother, Mrs. J. P. Edenfield of Lyons; brothers, Pershing Edenfield and Marshall Foch Edenfield of Lyons and Raymond Guyce Edenfield of Lakeland, Fla.

William Alfred Mendenhall

W. A. Mendenhall, 70, 1975 Family Physician of the Year, died March 3. Dr. Mendenhall also was the recipient of the Citizen of the Year award for the City of Chamblee and Chamblee Masonic Lodge in 1973.

The Emory graduate served a rotating internship at The Baroness Erlanger Hospital in Chattanooga, Tennessee. He served as a past president of the DeKalb County Medical Society and was a member of the Georgia Academy and American Academy of Family Physicians. He was a past master of the Chamblee Masonic Lodge and honorary member of the Legion of Honor of the state DeMolay.

Survivors include his widow, the former Ruth Eddleman; and sister, Mrs. J. D. Coffin of Council Grove, Kan.

Samuel Wilkins Norwood

Samuel Wilkins Norwood, 67, of Atlanta died March 4. Dr. Norwood was a former president of the medical staff at Crawford W. Long Hospital where he also chaired the obstetrics and gynecology section. He was a member of the South Atlantic Association of Obstetricians and Gynecologists.

Dr. Norwood, born in Marion, S.C., was graduated from The Citadel and the Medical College of South Carolina. His internship and residency were served at Chicago hospitals and during World War II, he was in the U.S. Army. Dr. Norwood was a founder of the Atlanta Yacht Club and former officer of the Snipe Class International Racing Association.

Survivor sinclude his widow, the former Ida Lois McDaniel; daughters, Mrs. Victoria Norwood Hutchinson of Redondo Beach, Calif., Mrs. William L. Tumlin of Marietta, Mrs. James P. Craft of Claremont, Calif.; son, Samuel W. Norwood, III of Atlanta; sisters, Mrs. William Dickson and Mrs. Allen Haskall of Marion, S.C. and Mrs. Marion Wright of Linville Falls, N.C.; brother, William Buck Norwood of Murrells Inlet, S.C.

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The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

Opposition to the Administration's proposals to change Medicare appears to be almost universal on Capitol Hill. The American Medical Association, the American Hospital Association, the AFL-CIO, the National Council of Senior Citizens are among many frequently crossed organizations that have joined in assailing the President's proposal.

The Administration has asked Congress to approve a new catastrophic benefit for Medicare coupled with much higher cost-sharing, to impose percentage "caps" on Medicare reimbursement for hospitals and physicians, and to change Medicaid into a block grant program for the states.

The House Ways and Means Health Subcommittee, headed by Rep. Dan Rostenkowski (D-Ill.), chaired three days of hearings as the Ford proposal was intended to take effect in March and Congressional approval was necessary. Any illusions the Administration may have entertained that some important support might surface for the Medicare plan were swiftly dispelled by the parade of hostile witnesses.

Rostenkowski chided the Administration for seeking early enactment without being able to provide Congress with a legislative proposal by the time hearings started. From the tone of Rostenkowski and other Subcommittee members in their questioning, there seems little chance of the proposal getting anywhere.

Raymond T. Holden, M.D., Chairman of the AMA's Board of Trustees, said "The proposed changes would not only be impractical, but would also be inherently unfair to all parties concerned. Unfortunately, the unfairness would be especially hard upon the beneficiaries of the Medicare program."

Unrealistic Proposal

Discussing the proposed four per cent limitation in 1977 on increases in Medicare physician reimbursement, Dr. Holden said "We must point out unequivocally that the percentages proposed are wholly unrealistic. The proposal ignores the realities occurring in our economy throughout the country. Moreover, inflationary conditions existing generally in our economy cannot justifiably be the basis for imposition of arbitrary and discriminatory ceilings on a single segment of the economy.

"To impose such arbitrary limits on only one segment of the economy and then to expect a continuation of beneficiary satisfaction for having benefits paid by Medicare (as promised by the program) is naive. The health care sector of our society cannot operate in a vacuum. It is subject to the same costs of living and costs of doing business as is any other segment of society. It cannot be expected to provide high quality care while having reimbursement limited to unrealistic levels."

The AMA Chairman told the Subcommittee the proposed limitations on increases in charges are in reality a response to a problem created in large measure by government itself. "Providers and physicians cannot be subject to ever increasing regulations and requirements . . . and yet be expected to keep charges at less than cost levels. These special requirements are on top of the inflationary problems faced by them along with everyone else."

Dr. Holden noted that both physicians and hospitals also "are experiencing highly unusual expenses relative to professional liability insurance."

"If the limitations were imposed, some health facilities could face bankruptcy," Dr. Holden said. "The patient will pay more, and the federal government will again have promised a broad program while seeking to limit payment for the care received. Under the guise of holding down costs to the federal government, the costs would, in fact, be increased to patients. The federal government must realize that once a program is legislated the service does not become free. But that, as with services generally, payment must be provided. In this instance we believe that it is unconscionable on the part of the Administration to shift costs to the beneficiary under the pretense of trying to limit the costs of the program to the federal government."

The proposals creating the four and seven per cent (on hospitals) limitations "are clearly discriminatory and arbitrary," he said. "They should be rejected summarily. Physicians have already been subjected to unreasonable and arbitrary controls. First the 83rd percentile formula, then the various phases under price controls, and now the 75th percentile which itself is controlled by an arbitrary economic index.

"These inequities are further magnified by the unrealistic Medicare practice which bases current payments upon data almost two years old. While physicians have accepted their responsibility in meeting the needs of the elderly, it is time for the government to meet its responsibility of fulfilling the commitment it made to the elderly under Medicare."

Bert Seidman, Director of the AFL-CIO's Social Security Department, said Labor was "dismayed" by the Administration's recommendations, which he declared would "create a most serious barrier to health care for the elderly." Seidman argued that the proposed

reimbursement controls on hospitals and physicians would simply shift the financial load to non-Medicare patients in hospitals and result in fewer physicians accepting assignment.

NHI Conversation

The sounds of a catastrophic-only national health insurance plan for this year still reverberate through Senate halls.

Senate Majority Leader Mike Mansfield (Mont.) and Republican Leader Hugh Scott (Pa.) recently agreed during a joint television appearance on backing catastrophic and on predicting it has a good chance of clearing Congress this year.

Chief Congressional sponsor of a catastrophic-oriented plan—Sen. Russell Long (D-La.)—said in a separate appearance that he believes Congress will approve his bill this session. Congress will go beyond what President Ford recommended in the way of catastrophic benefits for Medicare beneficiaries, Long said, and extend the concept to all Americans. The Chairman of the Senate Finance Committee said that for the average working man with a long siege of illness and very high medical expenses "we are going to provide some help for him, too."

The Administration has told Congress it won't propose a national health insurance (NHI) program until the economy brightens. However, Health, Education and Welfare Secretary David Mathews has conceded the plan—when submitted—will be close to the Nixon Administration's so-called CHIP plan mandating comprehensive private health insurance coverage to be offered by employers.

Mathews appeared before the House Commerce Subcommittee on Health as it opened the 1976 hearings on NHI. Under questioning from Subcommittee Chairman Paul Rogers (D-Fla.) Mathews said CHIP remains the basic Administration NHI plan and that proposing it "is a matter of timing."

Kickbacks

A Senate report charges that some clinical laboratories involved in Medicaid have operated on a kickback basis with physicians and clinics.

Chairman Frank Moss (D-Utah) of the Senate Special Committee on Aging said the report "concludes that, at least in the states which came under investigation, kickbacks are widespread among labs specializing in Medicaid business. In fact, it appears necessary to give a kickback to secure the business of physicians or clinics who specialize in the treatment of welfare patients."

The report focused on Illinois. Other states mentioned were New York, New Jersey, Michigan, California and Pennsylvania.

A staff witness told the Committee at a hearing that the staff estimates that at least $45 million of the $213 million Medicare-Medicaid payments to clinical laboratories is either fraudulent or unnecessary. Average kickback was 30 per cent of the lab's charge, the report estimated.

The report says a small number of labs control the Medicaid business in the involved states. In New York, according to the report, 17 facilities control 70 per cent of the Medicaid business; in New Jersey, 12 labs control nearly 60 per cent of Medicaid payments; in Illinois, 26 labs handle over 90 per cent of the volume.

In response to numerous press queries generated by the Committee's report including a filmed version of the charges carried nationally by CBS's program "Sixty Minutes," Max H. Parrott, M.D., AMA President, made the following statement:

"I would remind physicians and the public alike that the AMA Code of Ethics is very clear on the matter of laboratory charges.

The physician's ethical responsibility is to provide his patients with high quality services. As a professional man, the physician is entitled to fair compensation for his services. But he is not engaged in a commercial enterprise and he should not make a markup, commission or profit on the services rendered by others.

If after due process a physician is found to have violated the Code of Ethics in this or any other respect, he is fully liable for whatever professional penalties may be imposed, in addition to whatever penalties may be imposed by law."

Dictionary for NHI Lingo

Staff of the House Commerce Health Subcommittee has prepared a discursive dictionary designed to steer lawmakers through the maze of terms—medical, legal, and federal—involved in an intelligent discussion of national health insurance.

The 183-page document also will help physicians who have dealings with the federal government and Congress. It contains concise definitions of most of the pertinent legal and governmental terms and acronyms ("alphabet soup expanded") flavored with a touch of whimsy.

Illustrations range from a drawing of the lower intestines (see borborygmus) to a handsome full-page sketch of andreas vesalius and a two-page biography ("a wonderful man").

In an introduction, Subcommittee Chairman Paul Rogers (D-Fla.) said the developing debate on NHI ("a term not yet defined in the United States") employs a "bewildering array of new and unfamiliar terms." He described the discursive dictionary as "the first reasonably complete dictionary of terms relevent to the consideration of NHI and health care available."

Skipping through the document one finds definitions of such terms as triage, trolley car policy (benefit for injuries only when hit by a trolley car), slip law, respondeat superior (employers liability for malpractice of an employee), ping-ponging (passing patients from one physician to another), halo effect, gork, chainside and backdoor authority.

A typical definition—legislative history:

The written record of the writing of an act of Congress. It may be used in writing rules or by courts in interpreting the law to ascertain or detail the intent of the Congress if the act is ambiguous or lacking in detail. The legislative history is listed in the slip law (final version) and consists of the House, Senate and conference reports (if any), and the House and Senate floor debates on the law. The history, particularly the committee reports, often contains the only available complete explanation of the meaning and intent of the law.

Put together by Lee Hyde, M.D., professional staff

member of the Commerce Health Subcommittee, the dictionary is available in limited quantities on written request to: (Please enclose a self-addressed envelope) *Interstate and Foreign Commerce Committee, 2125 Rayburn House Office Building, Washington, D.C. 20515.*

Universal Indentifiers

The Health, Education and Welfare Department has been accused of attempting a shocking invasion of privacy in proposing to collect social security number identification of hospitalized patients and their physicians.

The AMA told HEW that "In this age of great concern over the right of privacy on the part of all citizens in our country, we are shocked that a federal department would now formally propose to establish a mechanism by which most physicians and every hospitalized Medicare, Medicaid, and Title V recipient could be classified, identified, matched, compared, reviewed and computerized with the impersonal ease of electronic machines."

The social security information would be part of the data collected by the Dept. for Uniform Hospital Discharge Abstract (UHDA) for federal medical programs. Purpose is to gather and coordinate statistical information which also could be used by planning bodies, accrediting organizations, hospitals, and private third-party payors.

The form would require the names of patient and attending physician and operating physician as well as their social security numbers.

The AMA noted in a formal comment that such use of social security numbers as universal identifiers has been criticized both by Congress and HEW in the past as a significant threat to peoples' right of privacy.

"There is well founded reason to fear that universal identifiers might be potentially available for abuse," the AMA said. "If, for example, each individual is identified in all of his activities by a single number and his activities are tabulated in a number of different record systems, all computerized, the universal identifier tends to erode the barriers between information systems. The fact that the social security number is already in such wide use makes any further encouragement for its use as contemplated by the proposed UHDA, highly dangerous." ■

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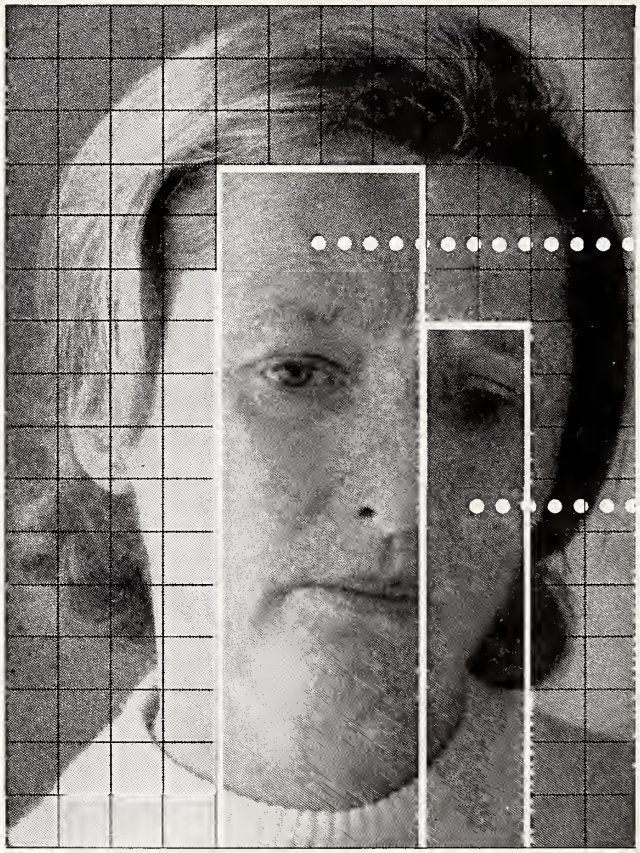
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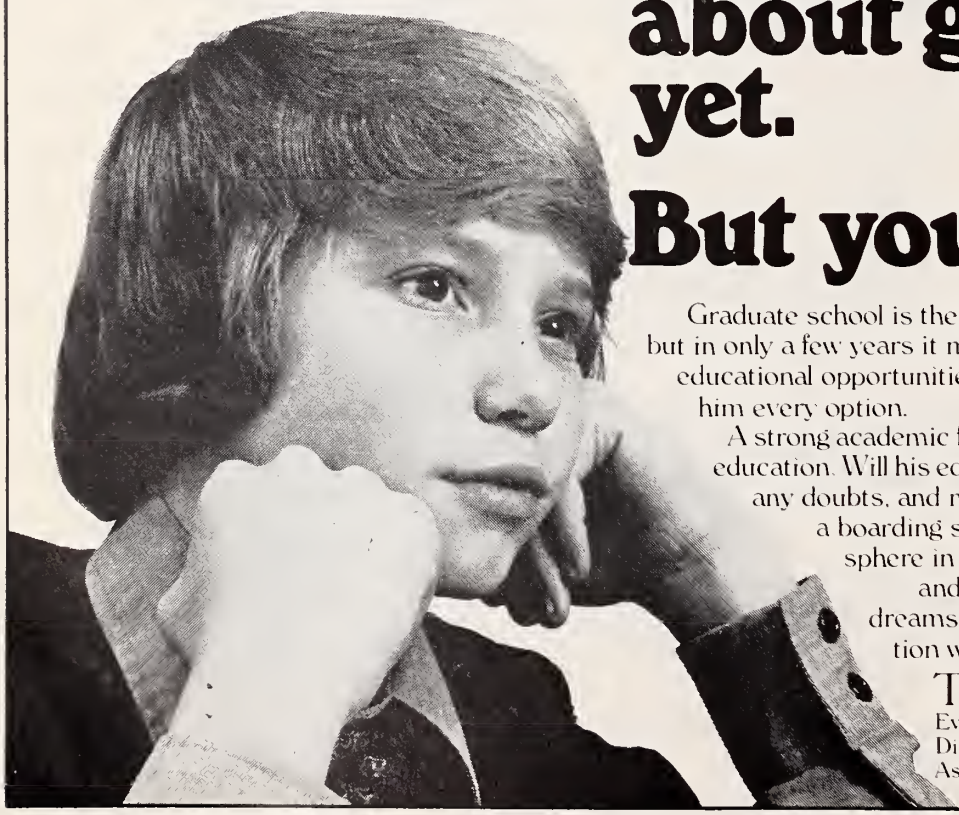
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Mag Rebuts the Moss Report on Unnecessary Surgery

HARRISON L. ROGERS, JR., M.D., *Atlanta**

The following is the text of the Medical Association of Georgia rebuttal to the report issued by the House Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce. This report usually is referred to as the Moss Report on Unnecessary Surgery and was published earlier this year following Subcommittee hearings in 1975. Many articles in the press and programs on television use this report as a basis for exaggerated accusations. Responding to the report, Jack Menendez, M.D. of Macon and I met March 11 in Washington with Congressman William Stuckey of Georgia who served on this Subcommittee, outlining our objections to the report. The Congressman asked us to prepare a rebuttal for inclusion in the Subcommittee records, and it is that report which follows. In addition, Grady F. Duke, M.D., a Griffin surgeon, was invited to appear on a rebuttal program prepared by the educational television network for May airing.

I. AMA Response to Report

Dr. James Sammons' letter (February 6, 1976) (AMA Executive Vice President) of rebuttal to Congressman John E. Moss succinctly conveys the position of organized medicine when he states, "The report is unsound in concept, unscientific in method, contains error in data and information, distorts testimony presented to the Subcommittee and bases its main conclusions on an incomplete and improperly defined study."

Dr. Sammons clarifies the actual testimony of key witnesses, Dr. George Zuidema (chief, Department of Surgery, Johns Hopkins School of Medicine) and Dr. Eugene G. McCarthy (professor of public health, Cornell University Medical College), to show that their comments and studies had been misrepresented and misunderstood. He underscores the problems related to provision of surgical services through prepaid group practice or other salaried surgeon arrangements by noting the dissatisfaction of patients as well as physicians with such alternative health care delivery plans.

Another point made by Dr. Sammons is the sloppy reporting of statistical information, which will be referred to again below, in a manner that results in a tremendous distortion of the real data on the incidence of certain surgical procedures. The AMA comments sharply rebut the Subcommittee report and raise serious questions about the motivation of the individuals involved in its preparation.

II. Editorial Comments in *New England Journal of Medicine*

Since some of the studies used by the Moss Subcommittee originally appeared in *The New England Journal of Medicine,* it is appropriate to consider the recent remarks printed by this prestigous journal's editor, Dr. F. J. Ingelfinger, entitled "Misuse of Information Printed in the *Journal*" (March 18, 1976). Dr. Ingelfinger scores the Subcommittee report, as well as a related series of articles by the *New York Times,* by pointing out the manner in which data had been manipulated and distorted.

He reviews the data on a specific procedure, cholecystectomy, and concludes that the number of so-called "avoidable deaths" attributed to this procedure would actually be one-tenth of the figure used in the report. Dr. Ingelfinger challenges both the media and the Congress to use the *Journal* material in a manner "that is consistent with their *(The Times* and the Subcommittee) status and reputation." Certainly if the Subcommittee had taken an interest in obtaining critiques of the studies it had so flagrantly abused, it may indeed have reached very

* Chairman of MAG's Committee on National Legislation, an AMA delegate, and former speaker of the House for MAG, Dr. Rogers' office address is 1938 Peachtree Road, NW, Atlanta, Ga. 30309.

different conclusions on the quality and quantity of surgical services provided in America.

III. DHEW Comments on Unnecessary Surgery

In spite of the problems that the public, organized medicine and even the Congress have with the Department of Health, Education and Welfare, it would be well to consider the Department's comments (Theodore Cooper, M.D., September 13, 1975, Appendix B to Subcommittee Report) on the subject of unnecessary surgery.

HEW's analysis of the various studies on this subject demonstrates that the evidence is inconclusive. As far as geographical differences in the incidence of surgery, Dr. Cooper notes that the studies have presented data on the existence of the differences but no conclusions are presented to explain them.

In further remarks, Dr. Cooper assails the McCarthy Study regarding a second opinion for surgery. He points out the unreliability of this portion of the study and suggests that it is inappropriate, at this time, to consider making the "second opinion" mandatory for federal health programs.

In closing his letter, Dr. Cooper suggests that screening prospective surgical cases against objective criteria will prove to be a more valuable tool to assure the quality and proper utilization of surgical services. This concept as well as "second opinion" methodology will be discussed further below.

IV. "Unnecessary Surgery" Defined

The primary source for the Subcommittee's definition of "unnecessary surgery" seems to be the statement of Dr. George D. Zuidema, chief of the Johns Hopkins School of Medicine's Department of Surgery and coordinator of "The Study on Surgical Services for the United States" (SOSSUS). Even though Dr. Zuidema cautioned at great length the possible misinterpretation that might be made of his definition, and even though he suggested that the term "contraindicated surgery" might be more effectively used to describe questionable surgical procedures, yet, in fact, the report fails to take into account the cautions expressed by Dr. Zuidema.

The report presents the six categories of unnecessary surgery without detailing the concerns which Dr. Zuidema presented at the hearings. For example, Category I dealing with discretionary surgery, such as cosmetic surgery, can be dismissed as unnecessary only if one is willing to accept vast regulation of the public's *right* to obtain such services which may serve only to satisfy its vanity. Category IV deals with operations to alleviate endurable or tolerable symptoms. The question to be raised here is whether the American public would be willing to live with hemorrhoids, varicose veins, prostatic disease, inguinal hernias, etc. In our society which places such high value on comfort and pleasure, it seems quite unlikely that such assuagable conditions would be tolerated for very long. Certainly in these categories, as well as others, there are abuses, but to arbitrarily dismiss all surgical procedures within this definition is a gross abuse of Dr. Zuidema's effort to assist the Subcommittee in dealing with an issue as subjective as this.

V. Pre-Surgical Screening on Second Opinion

Although studies such as McCarthy's and Widmer's may provide a significant insight into an aspect of our health care delivery system, great care must be taken so that the findings are not interpreted to mean more than the authors say they mean. The authors, for example, caution, ". . . the findings presented here cannot be applied to the general population undergoing elective operations" (*New England Journal of Medicine* article, December 19, 1974). Unfortunately, the Subcommittee staff did just what the article warned against—extrapolated the study's data for the entire population. In addition, contrary to the author's definitions, second opinions have been equated with the identification of unnecessary operations. Unfortunately, not much opportunity was provided to evaluate this concept's value as an identification of potential unnecessary surgery.

First, it must be recognized that legitimate differences of professional opinion do occur. These may be due to the surgeons' philosophy, training or the criteria applied. In some instances, one physician may be familiar with a patient, having followed him or her for some time, while the surgeon providing a second opinion usually has only a single opportunity to review a patient's history and condition, thus making his decision without the benefit of prolonged contact with the patient. His decision, therefore, may be less informed in terms of the patient's needs. Many times a second opinion is required, and any ethical surgeon will call in a colleague to assist him in reaching a decision. An issue that must be raised with McCarthy's study is his use of the term "second opinion." It seems that the "first opinion" is that of the referring physician—family practitioner, internist, pediatrician. In such a case, it certainly would not be uncommon for high percentages of disagreement by a surgeon with the referring physician's recommendations, as will be noted later in this critique. It would be of far greater interest to know the incidence of disagreement be-

tween two surgeons rather than the information McCarthy's study provides.

Second, as has been noted earlier, a decision should be based on consistent criteria. Unfortunately such is not the case in McCarthy's study. Over the last few years, hospital medical audit committees on their own initiative, the insistence of JCAH and the compulsion of HEW's utilization review regulations, have developed objective criteria by which to review hospital care. Only with such objective written criteria can one expect individual surgeons to base their judgment on something other than their personal, professional opinion.

Third, another major criticism of the McCarthy study, which the Subcommittee effectively disregarded, is its lack of follow-up of patients who had been refused surgical care in its initial report, although a study by McCarthy on this is underway currently. What effect does such a negative decision have on the quality of their life? Does their condition improve, stabilize or worsen without the surgery? At a later date, will surgery, perhaps more complicated surgery, have to be performed? These are some of the questions left unanswered, and yet the Subcommittee report offers "the second opinion" concept as a panacea for elimination of "unnecessary surgery."

Fourth, is it safe to assume that there will be a real savings to the government or third parties from the use of the "second opinion"? McCarthy errs and the Subcommittee report compounds the error on the amount of money to be saved if one considers the possible outcomes of postponed surgery. In addition, what of the cost of "the second opinion"? True, the surgeon's fee may be minimal, but what of his time which might have been better spent providing a needed service to a patient?

VI. Rationing of Surgical Services

Several of the individuals appearing before the Moss Subcommittee suggested, as their solution to "unnecessary surgery," pre-paid group practices and hospital-based, salaried surgeons. As is customary in such hearings, during which a conclusion is reached and witnesses are called to confirm it, no spokesman for the private practice, fee-for-service sector was called upon to testify. It seems strange, indeed, that in a nation which has the world's best medical care provided by thousands of physicians in private practice, no cognizance was taken of their contribution. In fact, the Subcommittee's report villifies these physicians and suggests that alternative health delivery models should be investigated.

As Dr. Sammons points out in his critique, evidence is now available that shows subscribers in pre-paid plans often choose to go outside for their health care. If the salaried surgeon refuses to provide discretionary surgical services, for patients suffering from hernias, hemorrhoids, or a problem attributable to the uterus and suggests that this is unnecessary, how long can the patient be expected to continue to suffer? Studies by David Mechanic in *Medical Care* dealing with HIP have indicated considerable dissatisfaction by subscribers and the frequent rejection of rationing of medical care by them. Our nation's citizens have become accustomed to reasonably prompt, quality surgical services, and it is unrealistic to expect that they will be satisfied with less than they are getting from the fee-for-service system of medical care delivery.

VII. Subcommittee Data Inaccuracies

The Subcommittee Report uses Medicaid data from a number of states to demonstrate the cost to the federal government for "unnecessary surgery." Unfortunately, as even the report suggests, data are hard to obtain. Even more important, however, the accuracy of the data is very questionable. In Georgia, for example, Medicaid data would have one believe that preteen girls and post 65-year-old women are being provided obstetrical services. If the experience in other states is similar, very little if any credence should be placed in the Medicaid data.

The information on hysterectomies in Nevada is another example of highly suspect data. Inquiries made to that state's Medicaid program revealed that the incidence of hysterectomies is less than half the figure used by the Subcommittee. Part of the reason for this error is the manner in which data are collected from claim forms. Since several physicians may bill for participating in performance of the same procedure, each of these claims was counted as being a separate hysterectomy. Closer scrutiny of the Medicaid data would doubtless reveal more of such problems.

It was not made clear in the Subcommittee Report that the surgical procedures included in the McCarthy Study were of a highly discretionary type with quite a small sample. Many categories such as procedures for children or the elderly, and obstetrics, were omitted. A more accurate reflection of the comparable national figure for surgery would be about one third of the Subcommittee's estimate. This would result in a much lower number of instances of "unnecessary surgery" even if one were to accept the report's definition.

Finally, the number of avoidable deaths is not established reliably in anything in the McCarthy study. This has been ably pointed out by Dr. Francis Moore of Harvard Medical School. It is certainly regretable that the Subcommittee did not give him an opportunity to review their data prior to its being used in their report.

VIII. Surgery in Georgia

As has been stated earlier, McCarthy's figures on the incidence of "unnecessary surgery" cannot be used for the entire country because of the known geographical difference which occurs.

In Georgia, it would be the contention of surgeons that no more than one per cent of the surgery performed could be considered unnecessary. It is the firmly held belief of Georgia surgeons that the general public is too well informed today to accept a recommendation for surgery which may not be necessary. Georgia's physicians with their standard of ethics and their excellent rapport with patients take the opportunity to consistently discuss the relative advantages and disadvantages of surgical therapy with their patients prior to surgery. The experience here would indicate that approximately one third of the patients referred by a primary care physician to a general surgeon will be turned down for surgical treatment. This may be because other medical procedures are available for the condition, the risk of surgery is too great or the service might be provided in the office.

In contacting hospital utilization review chairmen around the state about the incidence of "unnecessary surgery," their response has in general indicated a rate of one per cent. This percentage is given further substantiation in a recent report by Dr. Ralph Emerson *(New York State Journal of Medicine,* March 1976).

IX. Conclusion

In conclusion, it must be admitted that in medicine as in any other field, including politics, there are a few unscrupulous individuals. Fortunately, for the medical profession efforts are being made through state boards of medical examiners and medical associations to deal with the unethical, incompetent and disabled physician. In Georgia, for example, a medical disciplinary statute has been enacted and a disabled doctors plan has been initiated, both measures with the full support and cooperation of MAG.

In addressing the specific problem of the appropriateness of medical services being provided to federal health program beneficiaries, the state medical association and its medical care foundation have taken an active role. Since 1971, the state foundation has been reviewing Medicaid hospital and physician claims to assure the medical necessity of the services provided. One of its projects included a concurrent hospital review activity which in effect required a "second opinion" for hospitalization. The foundation has found a few problem cases, and these physicians have been reported to the Medical Association which has referred them to the State Board of Medical Examiners.

The Medical Association of Georgia participated for two years in HEW's EMCRO (Experimental Medical Care Review Organization) which worked with the state's medical and surgical specialty societies to develop criteria for evaluating the quality of care being provided. These are but two examples of the many efforts made by Georgia's physicians in their commitment to provide the highest quality of care to their patients. ■

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May 25-26, 1976
Miami, Fla.
Contact: University of Miami School of Medicine, P.O. Box 520875, Miami, Fla. 33152

AMERICAN GYNECOLOGICAL SOCIETY
May 25-29, 1976
The Homestead, Hot Springs, Va.
Contact: J. G. Moore, M.D., Department of Obstetrics and Gynecology, UCLA School of Medicine, Los Angeles, Calif.

INTERNAL MEDICINE
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June 11-12, 1976
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Category I Credit
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Grady Memorial Hospital
Category I Credit
Contact: Dept. of Ob/Gyn, Regional Training Center, Family Planning, Grady Memorial Hospital

CLINICAL APPROACH TO HEADACHE AND DIFFERENTIAL DIAGNOSIS OF WEAKNESS
June 17, 1976
University Health Service, Athens

Percutaneous radiofrequency retrogasserian rhizotomy provides safety and long-term efficacy in a surgical treatment for this painful problem.

The Clinical Features and Treatment of Trigeminal Neuralgia

NETTLETON S. PAYNE, M.D. *and* GEORGE T. TINDALL, M.D., *Atlanta**

TRIGEMINAL NEURALGIA, or tic douloureux, is a severe, disabling, and unfortunately common, painful disorder of the face. The condition has been known since ancient times and over the past several years, a variety of medical treatments, injections, and surgical procedures have been employed in an attempt to relieve the paroxysms of pain. Recent advances in treatment, particularly the increasing use of radiofrequency thermocoagulation have greatly simplified the management of this painful condition. In this presentation, the clinical features, diagnostic evaluation, and treatment of trigeminal neuralgia (TN) will be discussed.

Clinical Features

Trigeminal neuralgia is characterized by severe, lancinating facial pains that have a sudden onset and which last only a few seconds. The pain is paroxysmal and characteristically, is limited to the anatomic distribution of the trigeminal, or fifth cranial nerve. The paroxysms of pain are usually in the second and/or third divisions of the fifth nerve and infrequently in the first division. The pain can often be precipitated by stimulating certain areas of the face or the gingival margin, the so-called "trigger zones." Chewing, shaving, touching the skin of the affected dermatome, or a strong breeze on the face will often serve to initiate an attack. Many individuals have undergone repeated and usually fruitless, dental procedures, including extractions, in hopes of obtaining pain relief.

The diagnosis of trigeminal neuralgia can be established without difficulty on the basis of a thorough history. Typically, the neurological examination is normal.

Whenever abnormal neurological signs (depressed or absent facial or corneal sensation, unilateral loss of hearing, cerebellar signs, etc.) are found in a patient with trigeminal neuralgia, the physician should search for a structural intracranial lesion such as a posterior or middle fossa tumor or aneurysm.

Structural lesions should also be suspected in patients who have the onset of TN under the age of 40 years. Among other conditions, multiple sclerosis is frequently associated with TN in this particular age group. Also it is important to distinguish trigeminal neuralgia from the numerous other causes of facial pain, particularly atypical facial neuralgia, because the medical and surgical therapies to be described for trigeminal neuralgia are ineffective in those other conditions.

The diagnostic workup of a patient with classic TN includes history, physical and neurological examinations, routine laboratory studies and chest x-ray, and anteroposterior, lateral, and submentovertex skull roentgenograms. In patients with TN in whom the physician suspects a structural lesion, additional studies should include cerebral angiography with vertebrobasilar visualization and computerized axial tomography (CAT or EMI scan). The increasing use of the latter examination has virtually eliminated the need for pneumoencephalography. Cerebellopontine angle myelography may be useful in rare instances.

Treatment of Trigeminal Neuralgia

A. MEDICAL THERAPY:

After establishing the diagnosis of TN, the physician should institute a course of medical management. The following drugs are effective in many cases of TN:

1. *Diphenylhydantoin (Dilantin)**

Diphenylhydantoin is given orally in a dose of

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* Parke, Davis brand of diphenylhydantoin.

300 to 400 mg per day. It may be given in single or divided doses, whichever is best tolerated. The drug may induce ataxia, gastric distress, rash, hyperplasia of the gums, and a megaloblastic anemia. Although Dilantin* is initially effective in many patients, often it fails to provide long-term relief of trigeminal neuralgia. When the drug fails to provide effective pain relief, it should be withdrawn slowly with gradual reduction of the dosage over a 6 to 10 day period.

Before concluding that the drug has failed, the physician should check diphenylhydantoin blood levels to be certain that an adequate dosage has been taken. Therapeutic blood levels of Dilantin* range from 9 to 20 micrograms/100 ml.

2. *Carbamazepine (Tegretol)*†

Carbamazepine relieves trigeminal neuralgia in 60 to 80 per cent of patients treated. It is started in a dosage of 100 mg with meals twice a day and gradually increased by the addition of 100 mg every 12 hours until pain relief is obtained or side effects ensue. The usual daily dose is 400 to 600 mg per day, but one may go as high as 1200 mg per day. Side effects include skin rash, bradycardia, hypertension, and a transient or persistent leukopenia. The drug is contraindicated in patients with heart disease. Because of the hematopoietic toxicity a complete blood count should be performed biweekly initially, and later may be extended to monthly intervals and continued throughout the period of therapy.

B. SURGICAL THERAPY

1. *Injection and nerve avulsion*

Trigeminal neuralgia involving the first division is relatively infrequent, occurring in approximately five per cent of cases. Since it is difficult to inject all the fibers of the supraorbital and supratrochlear nerves with alcohol, the treatment of choice is surgical exposure and avulsion of these nerves, using local anesthesia. If pain recurs after this procedure, then radiofrequency coagulation of the nerve behind the gasserian ganglion (see below) may be necessary.

In the treatment of trigeminal neuralgia of the second division, injection of 1 ml of absolute alcohol into the infraorbital foramen, using a 25 gauge needle, is usually effective. If air is aspirated prior to alcohol injection, it indicates that the needle tip is situated in the maxillary sinus and will have to be reoriented. Alcohol injection can be repeated should the pain recur. If alcohol injection is unsuccessful, then the infraorbital nerve is avulsed, using local anesthesia. The incision is made along the upper gingival margin, and a subperiosteal dissection is carried out to expose the nerve in the infraorbital foramen. For cosmetic reasons, the incision to expose the nerve should not be placed in the skin directly over the infraorbital nerve. Trigeminal neuralgia usually recurs in six to eight months due to regeneration of the infraorbital nerve. Permanent relief of the pain will usually require radiofrequency coagulation of the second division fibers of the nerve behind the gasserian ganglion.

The pain of trigeminal neuralgia involving the third division may occasionally be relieved by the injection of 1 ml of absolute alcohol into the mandibular branch of the fifth cranial nerve at its exit from the foramen ovale. This technique should be carried out using repeated x-rays of the base of the skull during orientation of the needle tip to ensure its correct position in the foramen ovale prior to alcohol injection. Trigeminal neuralgia limited to the lower gum or lip can frequently be stopped by avulsion of the inferior dental nerve through a small trephine opening made at the angle of the mandible.

In general, trigeminal neuralgia involving the third division which does not respond medically usually requires that a definitive procedure be done, because the mandibular branch is relatively inaccessible to alcohol injection. Until recently, the definitive procedure of choice was subtemporal craniectomy and differential section of the posterior rootlets of the fifth cranial nerve, the classic Frazier operation.[1] Although this procedure can be done without difficulty by a skilled neurosurgeon who is familiar with the technique, it is still a major operative procedure. Since the introduction of radiofrequency thermocoagulation, craniotomy for TN is rarely performed.

2. *Radiofrequency thermocoagulation*

Presently the procedure of choice for trigeminal neuralgia that resists medical treatment and/or local nerve injections or avulsions is percutaneous destruction of the gasserian ganglion or its rootlets, using radiofrequency thermocoagulation. The percutaneous approach to the gasserian ganglion was first described by Härtel in 1914.[2] Many surgeons began using this method but the procedure never achieved widespread use because at that time there was no reliable method for controlling the extent of the lesion. The recent introduction of a temperature monitoring radiofrequency electrode has provided the precise control over the size and density of the lesion that is required. It permits destruction of only that portion of the trigeminal nerve necessary to relieve the tic pain, yet spare touch and proprioceptive modalities. The corneal reflex and motor division of CN V may also be preserved.

The procedure which is illustrated in Figures 1-3 is performed using local anesthesia and morphine and phenergan pre-medication supplemented with

† Geigy brand of carbamazepine.



FIGURE 1

A. A special Teflon insulated thin walled needle is inserted through the soft tissues of the face, beginning lateral to the labial commissure on the involved side.

B. Lateral x-ray of the needle in position within the gasserian ganglion.

intravenous methohexital (Brevital)* whenever placement of the electrode or thermocoagulation of the nerve is being performed. The needle electrode is introduced through the foramen ovale and placed among the desired rootlets, using a combination of x-ray and the conscious patient's responses to electrical stimulation. When the needle is properly positioned, a permanent lesion is made, using radiofrequency thermocoagulation. Thus this method will permit the selective treatment of the area of pain with sparing of the unaffected divisions. The technique results in relief of pain in the majority of patients and usually spares touch sensation in the side of the face treated. Since the radiofrequency technique does not require a general anesthetic or a formal operation, the procedure can be used in many elderly, dibilitated patients who would otherwise not be considered candidates for surgery.

* Lilly brand of methohexital.

Results From Radiofrequency Coagulation

A review of the literature[3-8] and experience with our own series of 27 cases (Table 1) indicates that the pain of trigeminal neuralgia can be relieved in 90 per cent of individuals.

In the remaining 10 per cent there is failure to achieve adequate denervation and the pain is not altered or returns within a few days of the surgery. A distinct advantage of this operative technique is that it may be repeated if necessary without great risk to the patient. Following a second such procedure the cure rate rises to 93 to 96 per cent, which is better than can be achieved with open craniotomy and section of the nerve behind its ganglion. In addition it has been possible to preserve touch in the

TABLE 1

RESULTS OF PERCUTANEOUS RADIOFREQUENCY THERMOCOAGULATION IN THE TREATMENT OF TRIGEMINAL NEURALGIA

Series	# Cases	% Achieving Pain Relief	Deaths	Complications
Tew[7]	200	90	0	Temporary extraocular palsy, 2 Corneal anesthesia, 6
Onofrio[3]	135	90	0	Temporary CN VI palsy, 1 Unwanted CN V anesthesia, 10 Neuroparalytic keratitis,* 2
Sweet & Wepsic[6]	214	91	0	Unwanted CN V, anesthesia, 15 Neuroparalytic keratitis,* 1 Other minor problems, 6
Turnbull[8]	41	100	0	Unwanted corneal anesthesia, 6 Neuroparalytic keratitis,* 2
Schurman et al[4]	183	93	0	None (Unwanted corneal anesthesia not mentioned)
Emory University	27	96	0	Unwanted corneal anesthesia, 1

* Keratitis was the only long term serious complication.

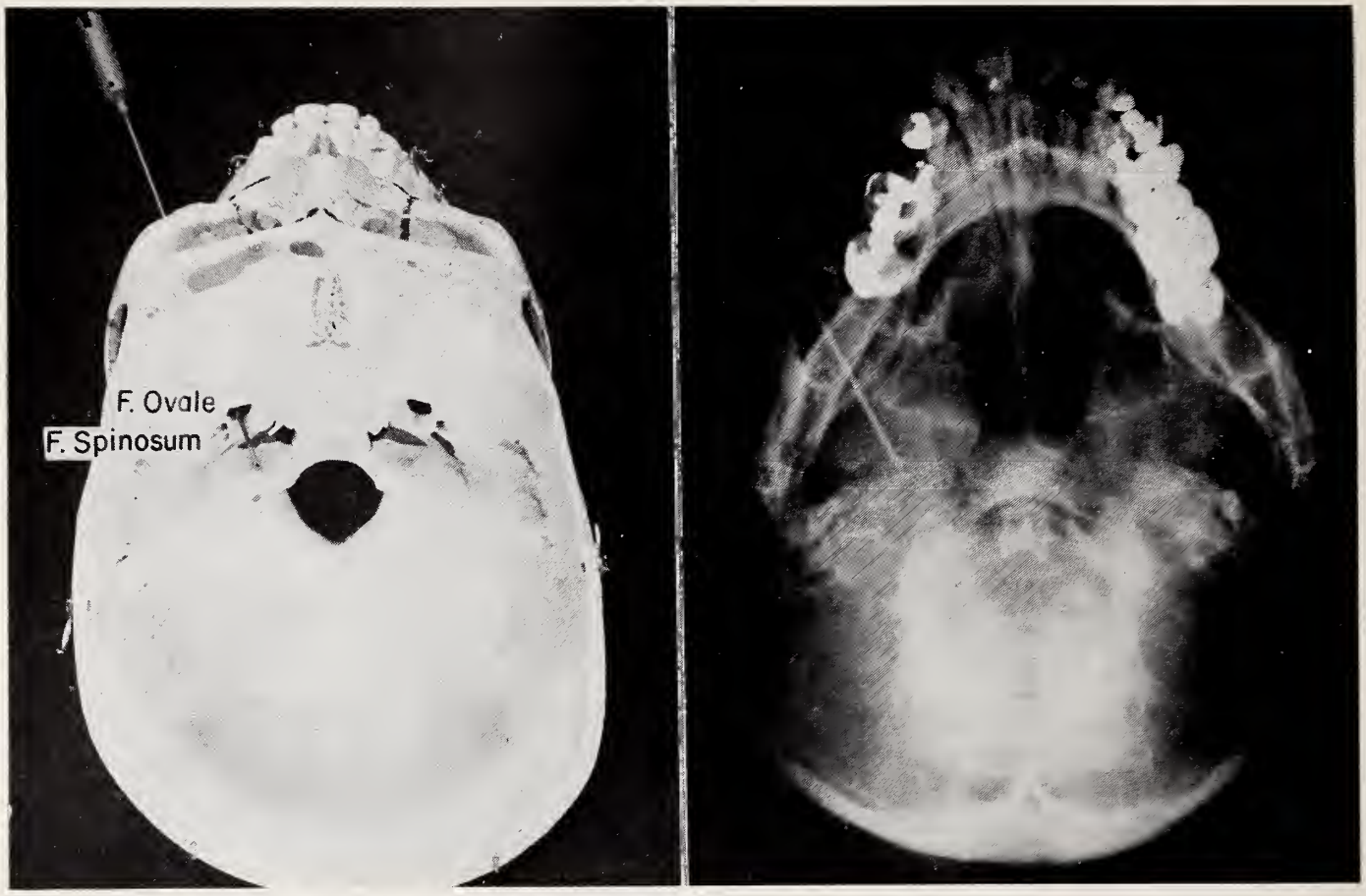


FIGURE 2

The electrode is guided through the foramen ovale under x-ray control with care being taken to avoid penetration of important contiguous structures such as the carotid artery, cavernous sinus, foramen spinosum, etc.

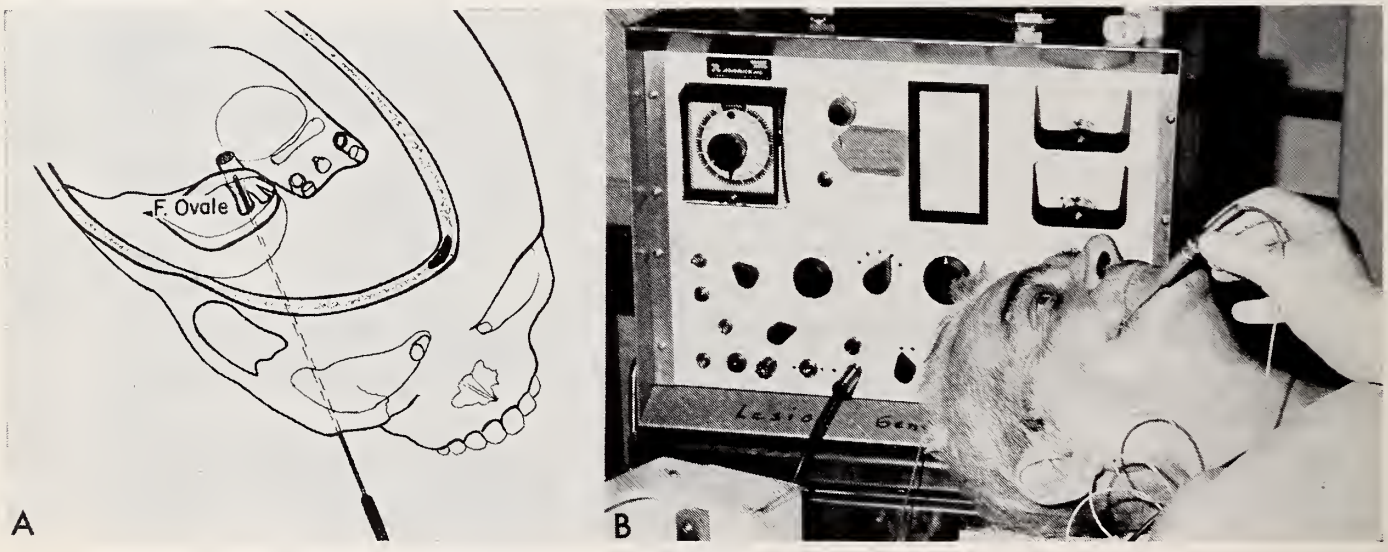


FIGURE 3

A. The position of the needle within the gasserian ganglion is shown. Methohexitol is administered during the final, painful, critical placement within the ganglion. B. Stimulation of the nerve root is carried out with a low voltage square wave and the distribution of referred sensation determined. If the placement is too medial, the muscles of mastication will contract on stimulation indicating contact with the motor root of CN V and the need for a more lateral placement of the electrode. Once the correct sensory referral is obtained the position of the electrode is checked radiographically and a preliminary lesion made under methohexitol anesthesia. After several minutes the patient becomes fully reactive and the extent of the lesion is determined by careful testing of the sensory and motor functions. Initial small lesions are enlarged with gradual increases in temperature and the duration of heating of the tip of the probe until the desired clinical result is obtained. Evaluation between each lesion enables fine control over the ultimate extent and degree of sensory loss. With this method it is possible to relieve the pain of trigeminal neuralgia with analgesia being the only deficit in the treated area.

areas of surgically induced analgesia in 80 per cent of the cases.[3] It is felt by those neurosurgeons performing this procedure, as well as their patients, that it is better to err on the side of producing too small of an initial lesion and preserve some sensation than it is to make a larger lesion with the attendent risk of a dense hemifacial anesthesia.

The most common complications are motor root injury, corneal anesthesia, and anesthesia dolorosa. Unilateral CN V motor weakness does not cause significant disability,[3, 5, 6] and usually resolves within a few months. It occurred in 40 per cent of Onofrio's series of 140 patients, yet was asymptomatic in all but four individuals. All other series report lower incidences of this complication.

Unwanted corneal anesthesia occurred in eight per cent of the cases of the combined series. However, neuroparalytic keratitis occurred in less than two per cent of these series and all have responded favorably to therapy to prevent corneal clouding.

Anesthesia dolorosa, a severe burning pain, quite different from that of trigeminal neuralgia, developed in from one to four per cent of patients. The etiology of this condition is not known, but it is found primarily in those few individuals with dense anesthesia.

Other complications, including transient CN VI paresis, puncture of the carotid artery, and penetration of the cavernous sinus, have been very infrequent and have all cleared without sequelae.

There are only two deaths reported in the world's literature known to be directly attributable to this procedure. However, in the 1,568 patients reported to date in the English literature there are no deaths. This is significantly better than the one to two per cent mortality rate associated with open subtemporal craniotomy, not to mention the added morbidity including facial nerve paralysis.

Discussion

The recently refined technique of RF thermocoagulation has several important advantages over other methods of surgical therapy used in the treatment of TN. Rhizotomy performed behind the gasserian ganglion results in indefinite relief of the pain of trigeminal neuralgia. Until recently, selective destruction of the trigeminal nerve behind the ganglion required open cranitomy with its associated morbidity and mortality. Physicians are reluctant to recommend such a major procedure to their patients, particularly those in the older age group who often have additional significant medical disorders. The percutaneous radiofrequency lesion made behind the gasserian ganglion provides long term relief without the dangers of craniotomy.

The reluctance of many physicians in suggesting cranial surgery has to a large extent been responsible for the continued popularity of procedures on the peripheral branches of the fifth cranial nerve. Alcohol blocks or avulsion of the involved peripheral nerve are still used and will relieve the pain temporarily. Unfortunately the patient is left with a dense anesthesia in the treated area which will not improve until the pain returns. In contradistinction to procedures carried out proximal to the gasserian ganglion where regeneration is not possible, nerve regrowth does occur in the peripheral nerve distal to the site of the surgical lesion. The pain usually returns between eight and 16 months following the injection or avulsion and repeated procedures are not generally as effective as the initial one. The problem of regeneration is obviated by the retrogasserian location of the lesion with the radiofrequency procedure.

Selective destruction is possible with radiofrequency thermocoagulation because of the relative heat sensitivity of the small poorly myelinated A delta and C nerve fibers which carry pain and temperature sensations and the heat resistance of the larger more heavily myelinated fibers which carry the other forms of sensory information.[6] Thus, carefully controlled heat exposure can be used to selectively destroy specific fiber types while sparing others.

Additional important advantages of the percutaneous radiofrequency retrogasserian procedure include minimal discomfort to the patient, who is hospitalized a total of two to three days. The operative morbidity is small and the patient is able to resume full normal activity in four to seven days. The total cost of hospitalization and care is significantly reduced.

Summary and Conclusions

Trigeminal neuralgia continues to present a difficult therapeutic problem. In the evaluation of individuals with this disorder it is essential that a thorough work-up be carried out looking for symptoms or signs suggesting a structural lesion of the skull or brain. In addition a CAT scan should be obtained in persons under 40 years of age or in those individuals with neurologic findings or atypical facial pain.

Tegretol is the drug of choice in the medical management of trigeminal neuralgia. It is effective in 60 to 80 per cent of patients initially, yet patient intolerance and gradual diminution in drug effectiveness create the need for a safe effective form of surgical therapy.

Percutaneous radiofrequency retrogasserian rhizotomy has recently been developed and for the first time provides safety and long term efficacy in a surgical procedure for trigeminal neuralgia. Pain relief is achieved in 93 per cent or more of patients, and complications are few and not life threatening. Pres-

ervation of normal sensation in non-involved dermatomes occurs in most treated individuals, and complete anesthesia even in the lesioned area occurs in only 20 per cent following this form of therapy. We believe that percutaneous radiofrequency retrogasserian rhizotomy should be recommended for all forms of drug refractory trigeminal neuralgia. ■

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A case of nearly lethal beriberi heart disease is reviewed which was induced by high consumption of beer at the expense of other sources of calories.

Shoshin in Georgia: A Case of Acute Fulminant Cardiac Beriberi

MILTIADIS A. STEFADOUROS, M.D., MAHFOUZ EL SHAHAWY, M.D. *and* A. CALHOUN WITHAM, M.D., *Augusta**

ALTHOUGH BERIBERI HEART disease is considered to be uncommon in the western hemisphere, an increasing number of cases have recently been reported, and the etiological role of excessive beer drinking has been emphasized.[7]

Patients with beriberi heart disease have been arbitrarily placed into one of two clinical groups; the more familiar one is characterized by tachycardia, bounding arterial pulses, and massive edema; less well-known is an acute fulminant syndrome consisting of near-complete vascular collapse, metabolic acidosis, intense peripheral cyanosis, and virtually unobtainable blood pressures in a "dry" patient. The latter, or "pernicious" type, recently reviewed, has not been widely emphasized in Western literature.[7] It has, however, been recognized in the Orient for perhaps 4,000 years, where it is often referred to as "Shoshin." This Japanese term implies both its acute nature and its cardiac involvement. In fact, Shoshin may be suddenly precipitated by physiological stress and thus apparently arise *de novo* or appear as a terminal event in the patient with the untreated chronic form.

Since untreated beriberi heart disease may be fatal, whereas complete cure is feasible once the disease is recognized, prompt diagnosis is extremely important. Although this is usually possible on clinical grounds in the chronic cases, in some instances, the findings are not so clear. This is especially true when Shoshin is the presenting picture. Biochemical studies are difficult, their value is somewhat controversial,[1] and they are not always available. Cardiac catheterization studies may provide additional support to the diagnosis, by proving the existence of high cardiac output state associated with very low systemic vascular resistance,[3, 9] but may be inadvisable in critically ill patients. Specific treatment with thiamin can be of significant diagnostic as well as therapeutic importance in such cases.

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Case Report

A 31-year-old white male security guard was transferred to the Talmadge Memorial Hospital in a semicomatose and seemingly moribund condition, after having been hospitalized elsewhere for three weeks and treated unsuccessfully for congestive heart failure. He had been well until three months prior to this admission when ankle edema, palpitations, fatigue and dyspnea on effort appeared and were gradually progressive. Following a febrile upper respiratory illness, these signs and symptoms became so severe that he was hospitalized. Blood pressure declined and was often difficult to obtain with recorded values as low as 78/50 mm Hg. During these three weeks his body weight increased by 20 kg despite vigorous treatment with digitalis and diuretics.

There was no history of previous cardiovascular disease, thyroid disease, or peripheral neuropathy. His family revealed, and later the patient himself confirmed, that he had been drinking excessive amounts of beer (18 cans or 4.5 L/day) for the last four months, during which period food intake had been severely reduced. He emphatically denied use of any other alcoholic beverage.

On examination, he was a well developed adult whose nutritional state could not be evaluated due to massive generalized pitting edema distributed over the four extremities and the sacral area. He was semicomatose and responded to vigorous stimuli only. His pulse rate was 110/min and regular. Initially, blood pressure was unobtainable but within a few hours was noted to be 90/40 mm Hg. The temperature was 95° and the respiratory rate was 24/min. The extremities were warm, and cyanotic, the face flushed, and the tongue "beefy-red." The jugular venous pressure was 4-5 cm above the clavicle at 45°, the carotid pulsations were prominent, and the

TABLE I

BIOCHEMICAL DATA BEFORE AND DURING TREATMENT

Date	Lactate (in mM/L) Arterial	Lactate (in mM/L) Venous	Pyruvate (in mM/L) Arterial	Pyruvate (in mM/L) Venous	L/P Ratio Arterial	L/P Ratio Venous
Before treatment	1.45	1.26	0.180	0.204	8.06	6.18
Three weeks of treatment	1.67	1.36	0.205	0.144	8.14	9.44

thyroid gland appeared normal. Chest examination yielded signs of right-sided pleural effusion. There were visible systolic pulsations at the left lower sternal border and the apex beat was felt at the fifth left intercostal space just outside the midclavicular line. The first heart sound was loud and the second was physiologically split with a loud pulmonic component. A grade 2/6 systolic ejection murmur was audible over the entire precordium but louder along the left sternal border, where third and fourth heart sounds were also heard. In spite of the low blood pressure, arterial pulsations were peculiarly brisk, and "pistol-shot" sounds were heard over the femoral arteries. Neurologic examination revealed no signs of peripheral neuropathy or any focal brain lesion.

Laboratory data: The hemoglobin, hematocrit, BUN, glucose and urinalysis were normal. The WBC on admission was 17,700/mm^3 with 81 per cent neutrophils, and returned to normal levels within four days of thiamin treatment. Pyruvate and lactate were measured in both arterial and venous blood on admission as well as three weeks after thiamin treatment and found to be normal on both occasions (Table 1). The initially low values of serum sodium (122 mEq/L) and chloride (78 mEq/L) were restored to normal after a few days of treatment. The serum proteins (total 4.6 g/100 ml, albumin 2.8 g/100 ml after one week of treatment) had risen substantially at the end of the third week (total 6.5 g/100 ml, albumin 3.4 g/100 ml). The electrocardiogram showed sinus tachycardia, low QRS voltage in the limb leads, and nonspecific ST segment and T wave changes (Figure 1). The chest film revealed slight generalized cardiomegaly, prominent main pulmonary artery, and confirmed the presence of pleural effusion (Figure 3).

The clinical impression was that of a high output state with remarkably low peripheral resistance. After having excluded hyperthyroidism, severe anemia, Paget's disease and A-V fistula by clinical or laboratory means, the diagnosis of cardiovascular beriberi was entertained. Digitalis and diuretics were discontinued and specific treatment was begun with 100 mg daily of thiamin intramuscularly, a multivitamin preparation per os, and salt and fluid restriction. A massive diuresis ensued, resulting in a weight loss of about 10 kg within 48 hours, and his clinical condition exhibited a dramatic improvement. He became alert and oriented, the blood pressure rose to 140/80 mm Hg by the fourth day of treatment, and the chest x-ray revealed disappearance of the pleural effusion and significant reduction in heart size (Figure 4). On this day, however, massive hematemesis and melena appeared. Despite repeated blood transfusions (10 units) the hemorrhage was uncontrollable. Surgical exploration was carried out and revealed

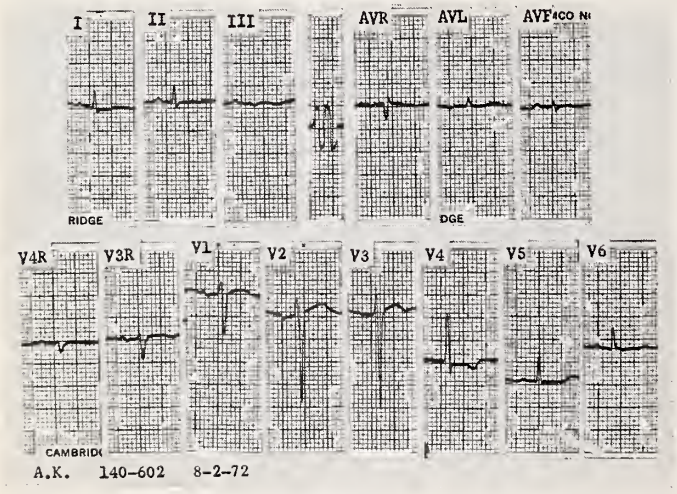


FIGURE 1

Electrocardiogram on admission. Low voltage is present in the limb leads and there are nonspecific changes in the ST-T segments.

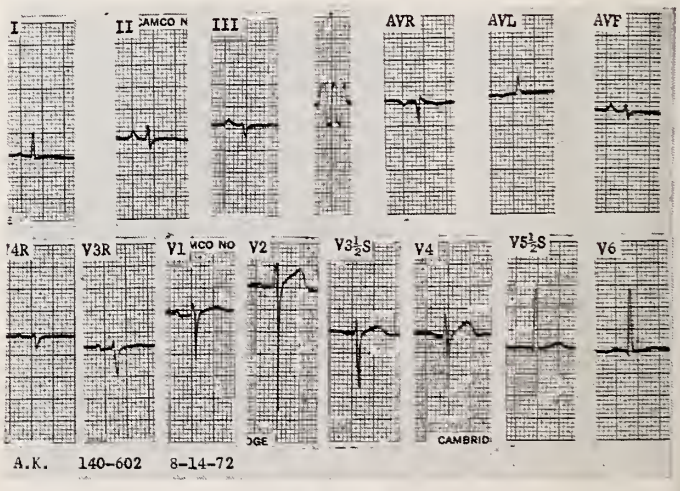


FIGURE 2

Electrocardiogram obtained after 11 days of thiamin treatment. Repolarization is nearly normal. Note increase in voltage in the precordial leads. In leads V3 and V5 the sensitivity of the recording is one-half the standard.

two bleeding peptic ulcers in the duodenum. Suturing of the ulcers, in conjunction with pyloroplasty and vagotomy, was performed. The patient tolerated the procedure well and had no further hemorrhage.

Postoperatively the treatment with thiamin and multivitamins was continued, but salt and fluid restriction were lifted. He continued improving and was discharged after three more weeks of treatment.

After his discharge the treatment continued with 50 mg thiamin per os and multivitamins, with further gradual improvement. The total weight loss was 25 kg, and his body weight after six weeks of treatment was 51 kg.

Discussion

The following criteria for a definitive diagnosis of beriberi heart disease have been proposed by Wagner et al[9]; 1) history of excessive beer intake for at least three months; 2) right-sided failure; 3) evidence of high output state in the absence of hyperthyroidism; and 4) low systemic vascular resistance that returns to normal limits within two weeks of thiamin treatment. All these criteria were clinically present in this patient. Under conditions of minimal caloric intake except from beer (estimated as over 2,000 calories per day), and in view of the high carbohydrate and low thiamin content in beer (6-9 μg per 12 oz can[5]), it is not astonishing that clinically overt thiamin deficiency developed within three to four months.

The presence of right-sided heart failure was clinically obvious in this patient. Diminished systemic vascular resistance, although not directly established, was inferred by the clinical evidence of high cardiac output associated with very low blood pressure. The diagnosis is so dependent upon correct evaluation of the hemodynamic state that quantitative confirmation at that time would have been reassuring, for the most commonly employed biochemical test, the serum lactate/pyruvate ratio is fallible and, in fact, was not diagnostic in this patient. It was felt, however, that cardiac catheterization would carry significant risk in view of the patient's poor condition, and that response to thiamin would probably be diagnostic. Echocardiographic methods of assessing cardiac output and peripheral resistance are sufficiently accurate to obtain this critical information, but were not technically feasible in this patient. Supportive data were obtained from systolic time intervals which showed an extraordinarily short pre-ejection period, high normal ejection time and an extremely low PEP/ET ratio (only 0.13). This is compatible with the high output-low resistance syndromes.

These noninvasive methods should prove valuable since the hemodynamics are not always obvious on physical examination.[7] Congestive cardiomyopathy, acute viral myocarditis, and even constrictive pericarditis (all low output syndromes) have been considered in some instances. Shoshin beriberi, of which this case can be considered an aborted example, is

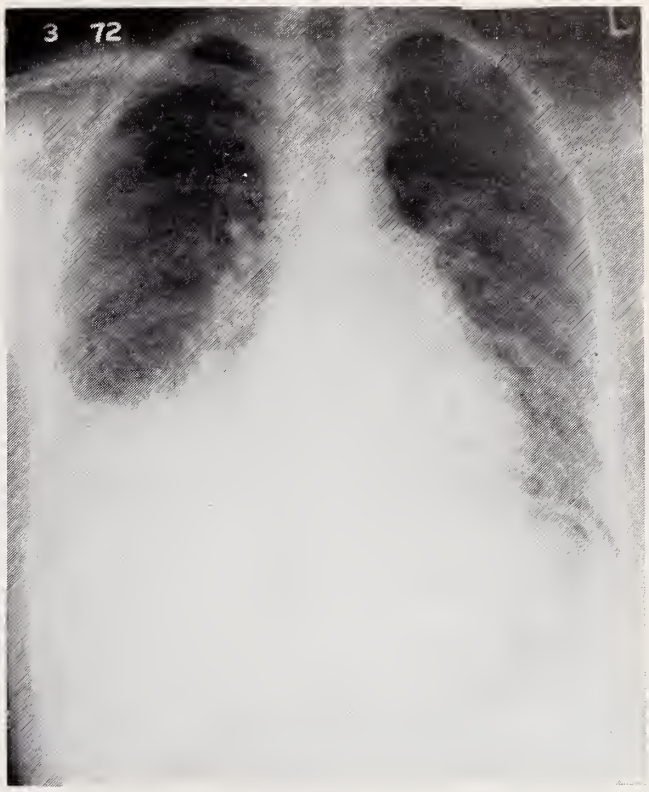


FIGURE 3

Chest film on admission. Cardiomegaly and pleural effusion on the right.



FIGURE 4

Chest film obtained after 11 days of thiamin treatment. Compare with the admission film of Figure 3.

in some instances the initial event rather than superimposed on the chronic form as in this instance. The "shocklike" picture suggests numerous possibilities.

An interesting feature of this case was leukocytosis, without any clinical or laboratory evidence of infection, that subsided soon after thiamin treatment. This finding has been noted by others.[4]

The initially observed flat or inverted T waves became normal within two weeks of treatment (Figures 1 and 2). A dramatic increase in QRS voltage also occurred. The latter might be due to disappearance of peripheral or intramyocardial edema, or to the regression of structural or biochemical changes in the myocardium. Both changes are in agreement with the experience of others.[6, 8]

Acute left ventricular failure has been reported[1, 2, 10] to occur soon after vigorous treatment with thiamin, presumably because of an abrupt increase in systemic vascular resistance before myocardial function has returned to normal. In our patient no clinical evidence of this response was observed.

It is also interesting to note that tachycardia, never excessive, persisted during at least three weeks of treatment. Heart rate appeared to be a poor index of the severity of this condition. Although initial response to thiamin is dramatic, complete recovery probably requires a month or more. ■

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1976 YEARBOOK DATA

The 1976 Yearbook of the Medical Association of Georgia will be mailed to active members of the Association with the August issue of the *Journal*. If information concerning your name, address or specialty has been inaccurate in past rosters, and you have not corrected this with our office in the past year, please fill out and send in the form below. If you have changed address recently, or plan to do so within the next few months, you may wish to supply us with the new address for the 1976 Yearbook. Those who have joined MAG within the past six months should provide their medical education number.

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A surgical procedure previously thought to be permanent and irreversible is, in fact, one that can be reversed.

Unlooping the Loop

WILLIAM J. MORTON, M.D., F.A.C.S., *Atlanta**

OVER THE YEARS, gradually, sometimes almost imperceptibly and at other times with great leaps and bounds, medicine continues to grow, expand and improve. Certain tenets remain unchanged, but more frequently, concepts learned while a medical student become challenged, and within a lifetime physicians may see previously dogmatic doctrines reversed. In the past 20 years surgical procedures have advanced, becoming more technically sophisticated depending upon the adroitness of the surgeon, so that it is difficult to maintain a level of constancy and dangerous to remain complacent. The purpose of this paper is to suggest to the reader that a previously thought permanent and irreversible surgical procedure is, in fact, one which can be reversed and therefore all of us should reevaluate and readjust our thoughts.

Ureteroileocutaneous anastomosis (ileal conduit or loop) is a remarkable technically easy means of diverting the urinary stream for numerous reasons. These range from (1) upper tract deterioration secondary to lower tract disease, (2) bladder cancer, (3) neurogenic bladder, (4) exstrophy of the bladder, (5) invasive pelvic malignancies and (6) fistula. First described by Bricker in 1951, it has provided the surgeon a tool wherein urine can be diverted without the use of catheters without particular fear of electrolyte imbalance and yet within the realm of social comfort to the patient.

The purpose of this paper is to challenge the doctrine that the ileal conduit is irreversible. Several authors have described taking down ileal conduits and reanastomosing the upper tract to the lower tract. Obviously not every conduit made would be a candidate for undiversion. Probably only a very select few of all the diversions performed will be acceptable candidates for undiversion yet it must be pointed out that the old premise of a patient wed to an ileal stoma with urine draining from the abdominal wall is no longer true and, depending upon the indication for the formation of the ileal loop, perhaps with reevaluation, the patient may have an opportunity to be reanastomosed.

Reevaluating the Situation

Let me hasten to sound the obvious—probably the majority of conduits are permanent and irreversible (i.e., because of bladder or gynecological cancer or neurogenic bladder disease) and also even those conduits which could be undiverted probably were indicated initially and were a lifesaving procedure at the time. However, as time passes and the patient settles down and renal function strengthens, reevaluation of the situation may be indicated.

An example of the first instance would be a situation where because of traumatic quadriplegia which results in neurogenic bladder, vesicoureteral reflux and subsequent upper tract damage, an ileal conduit may be indicated for relief. Obviously undiverting this patient with the same problem of neurogenic bladder would lead to the same situation all over again (even this situation may be challenged as investigators are making excellent progress with self-catheterization in neurogenic bladders which may eventually obviate the need for diversion).

An example of using the ileal conduit as a temporizing procedure would be, as occurred recently in my own practice, the following: C. L., a six year old caucasian female with a complicated urological history was about two and a half years post left nephrectomy for massive hydronephrosis and right ureteroneocystostomy with a Bradford-Young bladderneck revision. She had also had at least one other unknown type of surgical procedure on her bladderneck because of total urinary incontinence. When evaluated by me for this urinary incontinence, which had persisted for over two years since her last operative procedure, I noted two small fistulae in the mid urethra connecting to the vagina. Because of the technically difficult, if not impossible, procedure necessary to close her vesicovaginal fistula as well as the condition of the tissues locally and because she had demonstrated right total vesicoureteral re-

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flux again, I elected to divert her urinary stream with an ileal conduit, reevaluate her over the ensuing months, and perhaps reanastomose her upper and lower tracts if her urinary tract fistula resolves or becomes amenable to surgical correction.

Certainly a stoma and collecting device are much more socially acceptable now than constant vaginal leakage and in time she may be a candidate for repair.

Case Report

R. P., an 18 year old male, had a bilateral ureteroileal cutaneous anastomosis performed at age five because of bilateral hydroureteronephrosis secondary to vesicoureteral reflux (secondary to previous TUR of urethral valves). He was referred for possible undiversion. At the time of my examination, his history revealed no urinary tract infection although he was on urinary acidification. His physical habitus was of a stocky, tall young man obviously having reached excellent muscular and skeletal maturity. The urinalysis and culture was normal; BUN, creatinine and creatinine clearance were all normal. Voiding cystourethrogram revealed a bladder capacity of about 125 cc. with excellent bladder sensation and complete emptying. The intravenous urogram revealed excretion of the contrast medium with rather significant hydronephrosis and hydroureter bilaterally worse on the left than the right. There was only mild parenchymal thinning on the left side. The decision to reanastomose him was made and in fact performed rather readily. Both ureters were too short for direct anastomosis back into the bladder but the segment of ilium was taken down off the anterior abdominal wall and brought directly into the bladder with a submucosal tunnel in an antireflux technique. The patient is several months postoperative now and now has a bladder capacity of 400 cc. He is voiding with unexcelled glee. His renal function studies and urography have remained stable. Obviously this patient requires a lifetime of close urological supervision and may in fact require repeat urinary diversion if infection or further upper tract deterioration occurs. All evidence, however, supports that this should not occur and we have made a socially questionable situation acceptable.

This brief discussion of a new concept and surgical technique is presented to stimulate all of us to continue our learning process and also to remind us that medicine is constantly evolving and changing as we physicians also must continue to learn and readjust our values. In the words of Leonardo da Vinci, "The brilliant student will certainly outshine his teacher." ■

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

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NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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High Blood Pressure in Georgia

IN 1972, WHILE Elliot Richardson was Secretary of Health, Education, and Welfare, Mrs. Mary Lasker, an eminent medical philanthropist arranged an appointment to see him. She pointed out to him that high blood pressure was a very common health problem throughout the United States, that many surveys (including some in Georgia[1, 2]) had shown that the majority of people with high blood pressure were not getting any treatment or adequate treatment, and thirdly, that the recently published Veterans Administration Cooperative Studies[3] had proven that treatment of high blood pressure was very effective in preventing strokes, heart failure, kidney failure and malignant hypertension. She urged him to do something about this. She pointed out that this was an opportunity to make a major improvement in the health of the American people.

Secretary Richardson confirmed these facts with officials of the Veterans Administration and of the National Institute of Health and called together a "blue ribbon panel" to make recommendations as to what should be done. Out of this came the National High Blood Pressure Education Program (NHBPEP) with participation by the NIH, VA, Food and Drug Administration, voluntary health agencies and the national medical organizations. Dr. Theodore Cooper, now Assistant Secretary for Health, was named chairman of this group.

Success of First Education Program

In 1974, the National High Blood Pressure Education Program became fully operational. Nearly 100 national organizations cooperated in the planning and implementation of the first National High Blood Pressure Month in May, 1974. As a result, over 400,000 persons were screened and the 76,000 with elevated pressures were referred to a physician or a clinic for further evaluation. During the High Blood Pressure Month close to 10,000 articles on hypertension appeared in the newspapers, and articles on hypertension were published in magazines and professional journals having combined circulation of close to 4.5 million. During 1974 the program secured free broadcast time equivalent to $4 million on television and over $200,000 on radio.

Research was initiated in the spring of 1974 on a new method of educating the public and professionals about the problems of hypertension. Since many persons with high blood pressure are either unaware of their condition or reluctant to embark or adhere to treatment, studies of adherence, behavior

* Supported in part by the Georgia Heart Association and a grant from the Georgia Regional Medical Program.

and the educational interventions that may enhance a patient's initial and long-term adherence to therapy were begun.

Recent data (Table 1) suggest since 1971 there has been a sharp decrease in the number of Americans unaware that their blood pressure is high and an increase in the number of hypertensives whose disease is under adequate control. Also, since 1971, there have been marked increases in the number of initial patient visits to physicians for hypertension and hypertensive heart disease (up 38 per cent) and in total patient visits for these conditions (up more than 40 per cent). Based on data from the National Disease and Therapeutic Index, both have increased to a much greater extent than have initial and total physician visits for all causes (up about 17 per cent).[4]

The Southeast, including Georgia, has a much higher prevalence of hypertension and higher death rates from stroke and hypertensive disease than other areas of the United States. Surveys were done in Georgia in 1962, 1972 and currently which we can compare to the national survey figures (see Table 1). They show that Georgia has indeed kept pace with the nation, that there are fewer hypertensives unaware of their problem now than in 1962 or 1972 and that more hypertensives are under adequate therapy. However, the percentage for the groups diagnosed but not on therapy or that are currently on therapy but are not controlled has remained about the same. This means that mass screening with referral for diagnosis and therapy is not enough.

Improving Compliance

The major problem, i.e., keeping a person in therapy with controlled blood pressure, has not changed significantly since 1962, even with our better awareness and newer drugs. This probably is a problem of compliance, which involves both the therapist and patient. Often there are many barriers preventing the patient from remaining under treatment that the physician could correct. Such problems are irregular appointment scheduling, long waits in clinics and offices, excess cost in diagnostic studies and followup visits, and failure to educate the patient about hypertension and his risk. We have evidence from Georgia Heart clinics in community hospitals and from public health clinics that a well-trained nurse or other non-physician therapist can manage, monitor and follow patients with hypertension with a high degree of success in keeping patients under treatment and with good blood pressure control. We are hopeful that many of these approaches will be tried by private practicing physicians in group and single practices. A systematic, stepwise approach to drug therapy with attention paid to education, convenience and cost has been shown to result in at least 80 per cent of patients being adequately controlled.

May, 1976 is National High Blood Pressure Month again. We would hope that every physician in Georgia who is treating hypertension would re-examine his

TABLE 1
HYPERTENSION SURVEYS

	U.S.A. 1961-63 %	Georgia 1961-63 %	U.S.A. 1974-75 %	Georgia 1974-75 %
Unaware	44	41	29	25
Aware—Untreated	21	29	23	16
Treated—Uncontrolled	19	16	19	24
Treated—Controlled*	16	14	29	35

* Diastolic less than 95 mm. Hg.

office situation, his method of approach, and his therapy and see what he can do personally to make it easier for his patients to achieve and maintain diastolic blood pressures less than 90 mm Hg in at least 80 per cent of his hypertensive practice.

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Letter to the Editor

Dear Sir:

I want to endorse the opinions presented by Dr. Joseph A. Snitzer, III, in the January issue. He commented on the revision of Georgia's Adoption Code which would provide for better supervision of all adoptions in the State of Georgia, to provide for termination of the natural parents rights through a court proceeding, to disclose money spent in connection with the adoption for the purpose of identifying black market adoptions, and to provide for notifying the natural father of his rights.

In addition, I would like to urge consideration by MAG of a suit entered by the State of North Carolina against the National Health Planning and Resources Development Act. The basis for their suit is a constitutional one. In the opinion of Dr. James E. Davis, President of the North Carolina State Medical Society, "this law constitutes an infringement of the rights of the state and the practicing physician." I could not agree more.

This Act leaves very little freedom for the practicing physician or the citizens in need of medical care.

Very truly yours,

Stephen W. Edmondson, M.D.
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president's letter

The Foot Is In The Other Shoe



How well does MAG relate to the General Assembly? Prospective candidates must register between May 26 and June 9 for elections this fall. The entire cast in both the Senate and House of Representatives faces the public this year. MAG licked its wounds of defeat from the reorganization that created the Department of Human Resources four years ago. The effectiveness of our State Legislative Committee and our lobbyists, with the excellent help of many of the physicians, is showing now.

In May, designated representatives of the specialty societies will be able to converse with and learn more about the lawmakers in a symposium sponsored by MAG and Smith Kline & French at Pine Isle.

Many component county medical societies have introduced themselves to their local representatives through various programs. The quality of the relationships has varied, but some societies now are able to exert keener influence over their lawmakers.

Membership in GaMPAC has increased. The need for greater membership in this election year is evident. The district and state leadership of GaMPAC needs the input of the doctors and their spouses in choosing good candidates and working for these candidates.

Only one physician, Wilbur Baugh, was a member of the General Assembly this completed term. Now is the time to encourage greater involvement by our medical community.

Each of us recognizes the vast influence government has exercised over the practice of the healing arts. Any effect we have on the process of lawmaking basically falls back to our "one-on-one" continuing education efforts. The "homework" we do before "class" testifies to our motivation and positive footsteps in the "other shoe."

MAG has recognized members of the General Assembly with Certificates of Appreciation over the years. Current legislators among the recipients since 1970 include: Rep. Wilbur Baugh, M.D., Milledgeville; Rep. Harry Dixon, Waycross; Sen. W. W. Fincher, Jr., Chatsworth; Sen. Ed Garrard, Atlanta; Sen. Hugh Gillis, Soperton; Rep. Roy Lambert, Madison; Rep. W. W. Larsen, Dublin; Rep. Chappelle Matthews, Athens; Rep. Wayne Snow, Chickamauga; and Rep. Tom Taggart, Savannah.

Fleming Jolley

Fleming L. Jolley, M.D.
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Laetrile—Fact or Myth?

JOHN A. MANFREDI, M.D., *Decatur**

LAETRILE IS A COMPOUND which has been publicized as a drug for use in cancer therapy. It is also called Amygdalin and vitamin B_{17}. It was first referred to in the 1920's by Dr. Ernst T. Krebs, Sr., but was felt then to be "too toxic" for human use.

Laetrile is made from the seed of many fruits, but mainly from apricots. In 1952, E. T. Krebs, Jr., a biochemist in California, "purified" it, and stated it was now safe for humans.

The substance is felt to act by first entering the cancer cells, then enters into interaction with B-glucosidase, and results in the production of HCN. This, then, is reputed to destroy the cell by "immediately stopping all tumor respiration."

The name of Laetrile was introduced by Howard H. Beard, Ph.D., who stated that it was *lae*vorotatory and that amygdalin is a mandeloni*trile*. The substance is manufactured and distributed by the John Beard Memorial Foundation, Director Ernst T. Krebs, Jr., and McNaughton Foundation in California and Canada, but also in Mexico and Germany. It is not legally available in the United States.

Statements of Proponents

To evaluate the value of the substance as a cancer therapeutic agent, one must weigh the evidence for and against it. Two of the strongest proponents of it are Dr. Ernest Contreras in Mexico, and Dr. Hans Nieper in West Germany. They have presented little scientific data to support their claims of success in cancer therapy and have presented mainly isolated case reports of one or two cases.

There have been approximately 26 publications in favor of Laetrile, two in manuscript, one in press. One was a paper read before the Philadelphia Osteopathic Internists in 1954. Some 21 of 22 of the rest were in foreign journals. Eighteen were by Manuel D. Navarro, M.D. of the Philippines, many containing only a single case report.

One United States publication was "Chemotherapy of Inoperable Cancer Preliminary Report of 10 Cases Treated with Laetrile," by John A. Morrow, M.D., FICS, ASAS. In summary, it stated there was "possible regression of the malignant lesion," suggested in 10 cases. It "provided relief of pain, control of fever, and increased appetite and decreased adenopathy." He suggested that failures of it in the past might be improved by increased doses in the future, for better "anti-blastic effects."

Negative Evidence Emerges

The leading evidence against Laetrile began in 1953, when the Cancer Commission of the California Medical Association reported that to that date, there were 44 patients with objective data, and all had active disease or were dead. Of those alive, none had objective evidence of cancer control with Laetrile alone. Nine patients treated with Laetrile were autopsied by five different pathologists and none

* North DeKalb Mediplex, 2054-E Lawrenceville Highway, Decatur, Ga. 30033. Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

showed evidence of any chemotherapeutic effect. Also, in two independent studies by experienced research workers, Laetrile was shown to be completely ineffective in large doses on cancer in laboratory animals, in lesions readily influenced by useful chemotherapy.

In May, 1965, the *Canadian Medical Association Journal* reported that both Laetrile forms were ineffective in cancer therapy.

There have been frequent federal actions against the drug and its supporters. In 1962, Krebs and the John Beard Memorial Foundation pled guilty to five counts of violating the new drug provision of the Federal Food, Drug and Cosmetic Act, and were levied fines of $3,755 and Krebs was placed on three years probation. In March, 1963, the FDA reported "No competent, scientific evidence that Laetrile was effective for the treatment of cancer." In August, 1965, Krebs, Sr., 87, pleaded guilty in the U.S. District Court, San Francisco, of criminal contempt charges stating he disobeyed a restraining order, prohibiting shipment of Laetrile in interstate commerce. The Food and Drug Directorate of Canada also took action against the McNaughton Foundation around that time.

In January, 1966, Dr. Krebs again pleaded guilty to a contempt charge of shipping Laetrile, was found guilty on 11 counts, and had a one year suspended sentence. On April 20, 1970, the FDA issued IND 6734 to the McNaughton Foundation of California to test Laetrile. On April 27, 1970, a number of serious preclinical and clinical deficiencies were noted. On April 28, they were given 10 days notice of pretermination; and since no corrections were made, the IND was terminated May 12, 1970.

On September 1, 1971, the FDA announced in a news release that the Ad Hoc Committee of Consultants for Review and Evaluation of Laetrile found "no acceptable evidence of therapeutic effect to justify clinical trials." Five members of the committee were Non-FDA cancer specialists.

The National Cancer Institute on various occasions, in 1957, 1960, 1969, and 1973 have also reported failures with the drug against cancers.

On January 16, 1974, Dr. Saul A. Schepartz, associate director for Drug Research and Development of the National Cancer Institute wrote ". . . we obtained authentic clinical samples of Amygdalin MF manufactured in Mexico. . . . In summary, we can state that no evidence of activity was exhibited against the L1210, P388, B16 and Walker 256 tumor systems. Because of somewhat equivocal results with the Lewis tumor carcinoma, four experiments were carried out by our contractor at Southern Research Institute. The final report . . . concludes that no reproducible activity was obtained in that system. Thus, in all of the systems that we had tried until now, no activity has been found."

Finally, and most recently, Dr. Lewis Thomas, president of the Memorial Sloan-Kettering Cancer Center, New York, reported on animal experiments conducted for the previous two years on Laetrile. At the Science Writers Seminar of the American Cancer Society, he reported that there was no protective effects found against cancer. There was failure to provide any prolongation of life, inability to reduce the size of the tumor, and failure to inhibit the growth of the tumor.

I believe that all physicians in clinical practice must weigh the evidence for and against controversial medical problems, and reach their own conclusions. At this time, my own feelings are that until better and clearer scientific support for the substance Laetrile is presented, it must be considered myth, and not fact, especially with regard to its use in cancer chemotherapy. ■

Renin and Hypertension

JOSEPH S. WILSON, M.D., *Atlanta**

THE IMPORTANCE OF THE KIDNEY in the causation of hypertension has been recognized since the classic Goldblatt experiments in renal artery constriction. Reduction in blood flow to the kidney results in the secretion of renin, which acts to convert angiotensin I to angiotensin II. The latter is a potent vasoconstrictor and elevates blood pressure by reducing the size of the vascular bed. There is also evidence that angiotensin II stimulates aldosterone secretion which causes sodium reabsorption by the renal tubules, increasing volume. In the absence of renovascular disease, the increased volume would serve as an effective feedback mechanism to "shut-off" renin secretion and thus decrease angiotensin II levels. The presence of renovascular disease allows continued ischemia to result in continued renin excretion. Thus renal vein renin levels have come to be a useful adjunct in the diagnosis of renovascular hypertension, and when the ischemia is unilateral, differential renal vein renins may be helpful in diagnosis and prediction of response to surgical therapy.

Essential Hypertension Subgroups

In addition to this usefulness of renin levels in renovascular hypertension, recent articles by Laragh and his group[1–3] have indicated a role for renin determinations in delineating subgroups of patients with essential hypertension. When renin blood levels are correlated with 24 hour urinary sodium determinations (high dietary sodium depresses, low dietary sodium stimulates renin secretion) it is possible to separate three subgroups. A low renin group, comprising 20 to 30 percent of essential hypertensives, have a subnormal renin secretion in comparison to dietary sodium. These patients exhibit a milder form of hypertension with fewer complications such as strokes and heart attacks. The mechanism of hypertension is volume expansion, and they respond to diuretic therapy.

The majority of patients have normal renin and 10 to 15 per cent exhibit high renin hypertension. The pathogenesis in these patients is predominantly vasoconstrictor, mediated through the renin-angiotensin axis. Secondary aldosterone stimulation may result in volume expansion as well. Propanolol, the beta-adrenergic blocking agent, apparently blocks renal renin secretion, and lowers blood pressure at least in part by this mechanism. It is, therefore, logical to expect it to be effective in high renin hypertension, and indeed this is the case.

It is an interesting corollary that young blacks, who notoriously have a severe type of hypertension, have normal or high renin levels, whereas older blacks are usually low renin hypertensives and exhibit a milder form of the disease.

These observations by Laragh indicate the importance of renin levels, when

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correlated with sodium intake, in all hypertensives as an aid in prognosis as well as a guide to initial therapy. With availability of more reliable methodology, the renin level may prove to be an important part of the routine evaluation of the hypertensive patient. ■

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2. Laragh, J. H.: Vasoconstriction—Volume analysis for understanding and treating hypertension: The use of renin and aldosterone profiles; *Amer. J. Med.* 55:261, 1973.
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GOVERNOR SIGNS MALPRACTICE LAWS

Three physician-supported bills are signed into law by Gov. George F. Busbee, in ceremonies observed April 6 by members of the Medical Association and Georgia Academy of Family Physicians (GAFP). The new laws include S.B. 464, providing a two year statute of limitations on the filing of malpractice suits; H.B. 1446 (malpractice—ad damnum clause) in which dollar amounts of suits over $10,000 could not be publicized; and H.B. 1756 creating a Family Practice Advisory Board to encourage the training of more family physicians for Georgia. Present for the signing are (L-R) James A. Kaufmann, M.D., Atlanta, Chairman of MAG's Committee on State Legislation; Stephen C. May, M.D. of Kennesaw for GAFP; Earnest C. Atkins, M.D. of Atlanta, Secretary of MAG; Robert E. Wells, M.D., Atlanta, member of the Governor's Commission on Professional Liability Insurance; Wells Riley, M.D., Jonesboro, GAFP President; and Rusty Kidd, MAG Director of Legislative Activities.

Advertising by Physicians

(Federal Trade Commission Attacks Principles of Medical Ethics)

J. WINSTON HUFF, *Atlanta**

SECTION 6 OF THE Principles of Medical Ethics of the American Medical Association provides in part that a physician ". . . should not solicit patients."

The opinions and reports of the Judicial Council of AMA have very strictly interpreted this provision and have restricted practically all forms of advertising by physicians.

For example, the Judicial Council has stated that: "solicitation of patients, directly or indirectly, . . . is unethical. This principle protects the public from the advertiser and the salesman of medical care. . . ." "Solicitation, as used in the Principles means the attempt to attain patients or patronage by persuasion or influence." "The practice of medicine should not be commercialized nor treated as a commodity in trade. Respecting the dignity of their calling, physicians should resort only to the most limited use of advertising and then only to the extent necessary to serve the common good and improve the health of mankind."

Charge Against Price Fixing

These ethical principles have been challenged in a complaint filed some weeks ago by the Federal Trade Commission against the AMA, the Connecticut State Medical Society and the New Haven Medical Association. The complaint charges that these ethical restraints on advertising are in violation of the Federal Trade Commission Act provisions against price fixing. This Act prohibits all "unfair methods of competition," and the federal courts have held that price fixing agreements constitute an unfair method of competition. The complaint states that as a result of adherence to the principles of medical ethics, prices of physicians' services have been fixed, competition among medical doctors has been hindered and restrained and consumers have been deprived of financial information pertinent to the selection of a physician.

The complaint seeks an order requiring the defendants to cease taking any action which interferes with the free right of a physician to advertise his services or otherwise to engage in open competition with all other physicians.

Parallel Case for Attorneys

In 1975 the United States Supreme Court decided a parallel case involving the recommended fee schedules of Virginia attorneys. This decision may have implications for all ethical rules of professional associations. In this case, the Fairfax County, Virginia, Bar Association had published a recommended minimum fee schedule for various types of legal work and this schedule of fees was enforced by ethical sanctions of the Virginia State Bar. A client who had had to pay this

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

minimum fee in the closing of a home loan brought suit against the Virginia State Bar claiming that this fee schedule amounted to "price fixing" in restraint of trade and therefore violated the Sherman Antitrust Act. The Supreme Court of the United States held that the fee schedule in fact did constitute price fixing since it was shown that the fee schedule operated as a fixed price floor which was enforced through the prospect of professional discipline by the Virginia State Bar.

Thus the Virginia case tells us that the ethical standards of any professional organization may be subject to scrutiny when the federal government feels that such ethical standards tend to lessen competition in that professional area or activity. The American Bar Association wrestled with this problem at its recent mid-winter meeting in Philadelphia. Its Code of Professional Ethics has been amended to liberalize the nature and scope of information lawyers may include in professional law lists and directories and in the telephone directory yellow pages.

As recently as last year the Georgia Court of Appeals considered a case involving alleged advertising by a dentist. The Board of Dental Examiners of Georgia brought proceedings against a dentist arising out of an advertisement placed in a local Atlanta newspaper. The advertisement announced "expanded facilities" and advised the public that the new office ". . . is now open to serve all of your dental needs." The Board of Dental Examiners found that this violated the statutory prohibition against "soliciting dental business directly or indirectly" and suspended the offending dentist from practicing for a period of 30 days. The action of the Board of Dental Examiners was affirmed on appeal to the Georgia Court of Appeals.[1] If the position of the Federal Trade Commission is ever affirmed by the federal courts cases such as this will not be upheld.

Attorneys for the AMA are vigorously defending the Federal Trade Commission case. The AMA's position is that the Commission does not have jurisdiction of the case because the AMA is not a corporation "organized to carry on business for its own profit" as required by the Act. The AMA contends that it is in law and fact an "educational, scientific and charitable organization, and not a commercial business" and that this fact places it beyond the reach of the Commission.

This will undoubtedly be a long drawn-out affair and any major developments will be reported later in these pages. ■

REFERENCE

1. *Hinson v. Georgia State Board of Dental Examiners,* 135 Ga. App. 488.

CONFERENCE STUDIES INJURIES AND REHABILITATION

A joint training conference on "Rehabilitation Efforts for the Industrial Accident Victim," sponsored by Georgia Workmen's Compensation/Division of Vocational Rehabilitation, will be held May 27-29 at the Carriage Inn, Jekyll Island.

Paul L. Reith, M.D. of the Foundation at Warm Springs will moderate the initial discussions May 28: "Medical and Psychological Aspects of Vocational Rehabilitation," by Max P. Rogers, M.D., chief surgeon for the Southern Railway System; and "Back Injuries—Nonparalytic" by Frank Clippinger, M.D., associate professor of orthopedic surgery and chief of the Duke University Rehabilitation Unit.

Tom S. Howell, M.D. of Howell Industrial Clinic in Atlanta, is moderator for the second half of the program. Speaking on "Pain and Rehabilitation" will be Steven F. Brena, M.D., director of Emory Pain Clinic; and Stanley J. Smits, Ph.D., a professor in the Department of Counseling and Psychological Services at Georgia State University. Following these speakers will be a panel discussion on "Medical and Psychological Aspects of Rehabilitation."

I've told this before . . . .

(Ed. note: Author J. G. McDaniel, M.D. writes of the lesson in a Chinese adage found on a garden wall, reminding each of us of the fleeting nature of time and opportunity. Others wishing to contribute to this feature page should send their material to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.*

Enjoy Yourself—It Is Later Than You Think

In the early 1930's, an Ob-Gyn doctor by the name of Frederick Loomis, who lived in London, received the following letter:

Peking, China

Dear Doctor . . .

Please don't be too surprised in getting a letter from me. I am signing only my first name. My surname is the same as yours.

You won't remember me. Two years ago I was in your hospital under the care of another doctor. I lost my baby the day it was born.

That same day my doctor came in to see me and as he left he said, "Oh, by the way, there is a doctor here with the same name as yours who noticed your name on the board, and asked me about you. He said he would like to come in to see you, because you might be relatives. I told him you had lost your baby and I didn't think you would want to see anybody, but it was all right with me.

And then in a little while you came in. You put your hand on my arm and sat down for a moment beside my bed. You didn't say much of anything but your eyes and your voice were kind, and pretty soon I felt better. As you sat there I noticed that you looked tired and that the lines in your face were very deep. I never saw you again, but the nurses told me that you were in the hospital practically night and day.

This afternoon I was a guest in a beautiful Chinese home here in Peking. The garden was enclosed by a high wall, and on one side, surrounded by twining red and white flowers was a brass plate about two feet long. I asked someone to translate the Chinese characters for me. They said: *Enjoy Yourself —It Is Later Than You Think.*

I began to think about it for myself. I had not wanted another baby because I was still grieving for the one I lost. But I decided that moment that I should not wait any longer. Perhaps it may be later than I think, too.

And then because I was thinking of my baby, I thought of you and the tired lines in your face, and the moment of sympathy you gave me when I so needed it. I don't know how old you are but I'm sure you are old enough to be my father; and I know that those few minutes you spent with me meant little or nothing to you, of course, but they meant a great deal to a woman who was desperately unhappy.

So I am so presumptuous as to think that in turn I can do something for you, too. Perhaps it is later than you think. Please forgive me, but when your work is over on the day you get my letter, please sit down very quietly, all by yourself, and think about it.

Marguerite

Dr. Loomis did think about it and immediately took a three month vacation. Later on he published the letter and those Chinese characters have caused many people to stop and think and enjoy themselves for a little while. ■

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(Correction from April JMAG)

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SOCIETIES

The **Cobb County Medical Society** has established a memorial scholarship fund following the February deaths of three members in an airplane accident. The fund will be administered by Kennesaw Junior College and contributions will be accepted from anyone wanting to recognize distinguished citizens of Cobb County and the Cobb Medical Society. It is expected that scholarships will be awarded yearly to KJC students.

Lawrence Custer, attorney for the Society, was the guest speaker for their March meeting. The May meeting was scheduled May 4 in the Ramada Inn, Marietta.

Members of the **DeKalb Medical Society** talked with their congressman, 4th District Rep. Elliott H. Levitas at their monthly meeting April 19. During the Input Forum which preceded the meeting, Stanley P. Aldridge, M.D. chaired a discussion of "Access to Care—Problems and Solutions." Future speakers invited by the society include in June, Gene Dyson, Dean Rusk in July, Judson Ward on the Bicentennial in August, Cong. Andrew Young in September, Alton Ochsner in October and Gov. George Busbee in November.

AMA President Max H. Parrott, M.D., addressed the **Georgia Medical Society** April 13 on the topic, "Big Deeds: Small Price." The society was co-sponsoring a continuing education program in mid-April with the American Medical Electroencephalographic Association.

PERSONALS

First District

Carl Rosengart of the Memorial Medical Center recently accepted a certificate of accreditation of the AMA for the Center's continuing education program. Dr. Rosengart is director of medical education and praised "the foresight of the board of trustees, the administration and the medical staff" in establishing and supporting CME at the Center.

Second District

John M. McCoy of Moultrie lectured on "Intra-articular Radiotherapy with ^{90}Y" during the April meeting of the Georgia Society of Nuclear Medicine.

Fourth District

Richard S. Colvin of Atlanta has been cited for distinguished achievements by being named a Fellow of the American College of Radiology. Dr. Colvin is an Emory graduate affiliated currently with Emory University Hospital, Grady and the VA Hospital in Decatur.

Fifth District

Atlantan **Milton F. Bryant** has been appointed as a consultant concerning venomous animal bites and stings for the American Association of Zoological Parks and Aquariums.

Recently joining Project HOPE is **Ira A. Fergusen** of Atlanta, who will serve as a surgeon educator in Tunisia. Dr. Fergusen was graduated from Emory University where he has been serving as an assistant professor of surgery.

Lecturing at the April 3 meeting of the Georgia Society of Nuclear Medicine were: **Edgar D. Grady** of East Point, on "Internal Hepatic Radiotherapy with ^{32}P-Colloid"; **James H. Larose,** East Point, on "Internal Hepatic Radiotherapy with ^{90}Y-Microspheres"; and **Oliver A. Sorsdahl** of Atlanta, on "Bone Scanning in Malignant Disease."

Charles R. Hatcher has become the director of Emory University Clinic following the retirement of **Robert L. Brown.** Dr. Hatcher is a native of Bainbridge who received his medical degree from the Medical College of Georgia. His post-doctoral training in surgery was at the Peter Bent Brigham Hospital in Boston and Johns Hopkins Hospital in Baltimore. He joined the Emory faculty in 1962. Dr. Brown now will become professor emeritus of surgery at Emory after 10 years as director of the Emory Clinic and professor of surgery. Dr. Brown is a graduate of Harvard Medical School.

Garland D. Perdue of Emory was course director for an April conference of surgeons on "Perspectives in Vascular Surgery" in Atlanta. Also participating in the program with other members of the Emory Department of Surgery under the chairmanship of W. Dean Warren.

Joseph A. Wilber of Atlanta participated in the Scientific program of the 108th Annual Session of the Mississippi State Medical Association May 5 in Jackson, Miss. Dr. Wilber discussed, "Hypertension—A Community Affair." He is president-elect of the Georgia Heart Association and supervisor of the Adult Health Section for the Georgia Department of Human Resources.

Sixth District

Dublin physician **John Bell** has been elected new chairman of the State Board of Regents and will assume the post in July. Dr. Bell is a family physician who has been a member 13 years of the Board which has charge over 32 institutions of higher learning.

Seventh District

Ralph R. Greene of Ringgold has been elected to the Board of Trustees of the Hospital Authority of Walker, Dade and Catoosa Counties. He is a graduate of the Medical College of Georgia and is vice chief of staff for Hutcheson Memorial Tri-County Hospital.

Ninth District

Paul T. Scoggins of Commerce was featured in a *Commerce News* article recently, in which he commented on the changes he has seen in the practice of medicine over the past 47 years. In addition to his practice, Dr. Scoggins has been active in public life, serving as city councilman and mayor of Commerce.

Tenth District

Paul G. McDonough of the Medical College of Geor-

gia presented the William Diehl Memorial Lecture on "Primary Amenorrhea" at the Lutheran Hospital of Maryland in Baltimore. He also participated in the recent Ross Conference on Critical Approach to Common Pediatric Problems in Adolescent Gynecology.

J. G. Smith, Jr. of Augusta chaired a workshop on research and academic manpower funding in dermatology in Bethesda, Maryland. Dr. Smith also has been appointed to the editorial board of the *Southern Medical Journal*.

Leland D. Stoddard is the new secretary-treasurer of the U.S.-Canadian Division of the International Academy of Pathology and named a member of the Intersociety Pathology Council.

W. B. Strong was presented the Theodore and Susan Cummings Humanitarian Award for 1976, given for noteworthy contributions to international understanding in cardiology. The award is granted by the American College of Cardiology.

DEATHS

Ivan R. Elder

Bremen physician Ivan R. Elder, 58, died February 28 in Higgins General Hospital where he had been chief surgeon.

Dr. Elder was a graduate of Vanderbilt University where he also completed his internship and residency. During World War II, he served in the armed forces. Dr. Elder completed a Mayo Fellowship in 1947 in Utah, then moved to Columbus in 1947. In 1959 Dr. Elder moved to Bremen, serving at Higgins General Hospital and as chief of staff at Haralson County Nursing Home.

Active in public affairs, Dr. Elder worked on the city zoning board and housing authority and was a member of the Baptist church.

Survivors include his widow, Mrs. Jerry Elder; daughter, Mrs. Tommy Waddell of Durham, N.C.; four sons, Roddy Elder of Tuscaloosa, Ala., Knox Elder and Albert Elder of Bremen, and Curt Elder of Columbus; and step-son, Jimmy Williams of Huntsville, Ala.

George Yellot Massenburg, Jr.

Macon surgeon and proctologist, George Yellot Massenburg, Jr., died March 14 in the Medical Center of Central Georgia. He was 54.

Dr. Massenburg, a native of Macon, served on the staffs of Middle Georgia Hospital and Coliseum Park Hospital in addition to the Medical Center. He was a member of the American Board of Proctology and American Institute of Proctology.

His medical degree came from Duke University, and his internship and residency were served at the medical school of the University of Maryland in Baltimore. His preceptorship training was completed at Baltimore City Hospital.

Dr. Massenburg was a member of Christ Episcopal Church, the Macon Civic Club, Elks Club and Idle Hour Country Club. In the U.S. Air Force he had attained the rank of lieutenant colonel.

Survivors include his widow, Mrs. Marjorie McCarty Massenburg; daughter, Miss Jenifer Lee Massenburg; son, Robert Shedd Massenburg, all of Macon; two sisters.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

The American Medical Association has supported President Ford's decision to undertake a mass immunization program against the swine influenza virus.

The President will ask Congress for $135 million to undertake the program in an attempt to stave off a possible epidemic of the virus this coming fall and winter.

The AMA said it felt the President's decision was "absolutely correct."

Most of the medical community seemed to agree with the Ford decision, though many pointed out it was a tough one. "This is a most difficult decision," said Albert B. Sabin, partner in the development of the polio vaccines, "It has an aspect of—you're damned if you do, and you're damned if you don't."

AMA leadership is scheduled to appear before both the Senate and House in support of the Ford decision.

The AMA statement in full:

> "The American Medical Association supports the decision of President Ford to undertake a massive national immunization campaign against the swine influenza virus. Under the circumstances, we believe his decision is absolutely the correct one.
>
> "The AMA stands ready to assist in the national campaign in any way possible, including organizing the medical profession to insure that every person who wants to be vaccinated will be—regardless of ability to pay.
>
> "We speak for the medical profession in committing the doctors of this nation to make whatever efforts are necessary to vaccinate the entire population. It will not be easy, but it can and must be done."

Medical Fraud

A federal-state campaign to reduce Medicaid fraud and abuse has been launched by Health, Education, Welfare Secretary David Mathews.

A team of federal and state Medicaid examiners will begin its work in Massachusetts soon at the invitation of Gov. Michael Dukakis. Another team will begin operations in June in Ohio at the request of Gov. James Rhodes.

HEW said it plans to focus the joint effort on states with the largest Medicaid programs, with reviews in at least five states this year.

The federal-state examiners will have two basic objectives, Secretary Mathews said. They will identify fraud and abuse and refer specific violations for possible prosecution. They will help states develop efficient program management and abuse detection systems.

HEW has developed a computerized Medicaid management information system (MMIS) to aid in the processing of claims. MMIS will alert a state if, for example, a patient was in a hospital the same day a physician claimed to have treated him at home, or if a pregnancy test was ordered on a male, HEW said.

HEW is assembling a Medicaid fraud and abuse unit of 108 people in the Medical Services Administration, and a criminal investigative branch of 74 investigators which will report directly to Under Secretary Marjorie Lynch.

HEW said it will coordinate its Medicaid investigative efforts with the Department of Justice and the Internal Revenue Service.

Mathews said he plans to invite representatives of national health services provider organizations to Washington shortly to solicit their ideas and to urge them to undertake a self-policing program and to assist the states in identifying potentially fradulent providers.

"We recognize that the overwhelming majority of health care providers are ethical and professional," Mathews said. "They share our desire to bring efficiency to Medicaid in its management and in the quality of health care it offers. We want to ferret out the comparative few who break the law. We believe the health professions organizations will give us their enthusiastic support in this effort."

Heading the HEW office of investigators will be John J. Walsh, senior investigator for the Senate permanent subcommittee on investigations and former FBI agent.

Talmadge Proposes Legislation

Major changes in the Medicare-Medicaid programs are called for in proposed legislation introduced by Sen. Herman Talmadge (D-Ga.). The proposal would establish incentives for physicians to accept assignment; restrict payment methods for hospital-based specialists; mold Medicare, Medicaid, and the Bureau of Quality Assurance into a single agency; and set up reimbursement incentive programs for hospitals.

Talmadge, Chairman of the Senate Finance Subcommittee on Health, said in a Senate speech "either we make Medicare and Medicaid more efficient and economical or we reduce benefits. We have just too many worthwhile demands on the limited federal dollar to be able to allocate increasingly disproportionate amounts to Medicare and Medicaid."

Hearings will be held sometime this year, Talmadge promised, but he set no date. He stressed that the proposals are not "frozen in concrete" and are subject to change following the hearings according to the testimony received.

The influential Senator surprised the health field last year when he made a Senate speech outlining the ideas finally put in legislative form recently. Many of the recommendations are controversial, especially the reorganization of the health activities at HEW that are bound to be opposed by the administration and the restrictions on payment of hospital-based specialists.

Talmadge describes the specialist provision as follows:

"Under the legislation specialists—such as certain

radiologists, pathologists, and anesthesiologists—would be eligible under Medicare-Medicaid for fee-for-service, or other reasonable fixed compensation agreed upon with a hospital, for services which they personally render or which are provided under their direct personal supervision. For their administrative and general supervision of an X-ray, laboratory, or anesthesia department, the hospital could compensate them on a basis comparable to what a salaried radiologist, pathologist or anesthesiologist receives for comparable time and work. No percentage, lease, or direct billing arrangements would ordinarily be recognized for Medicare or Medicaid reimbursement purposes. . . .

Physicians who choose assignments, to be called Participating Physicians, would be able to submit simplified and fewer claims and receive a $1 per patient bonus for most office visit charges. Medicaid would have to pay not less than 80 per cent of the Medicare reasonable charge for non-surgical care. As a means of encouraging physicians to move into physician shortage areas, new physicians could establish customary charges at the 75th percentile of prevailing charges in the locality, rather than the present 50 per cent.

A single administration for health care financing (CAPS) would contain the present Medicare, Medicaid and Bureau of Quality Assurance Agencies to be headed by an Assistant HEW Secretary. Within this Agency a central fraud and abuse unit headed by an inspector general would monitor performance and violations of law.

The bill would abolish the Health Insurance Benefits Advisory Council.

A new reimbursement system is designed to reward hospitals with less than average operating costs and penalize those with higher costs.

Cowan Resignation

James Cowan, M.D., has resigned as Assistant Secretary for Defense for Health and Environment. Among those reported under consideration as Cowan's successor is Malcolm Todd, M.D., Immediate Past President of the American Medical Association. Dr. Cowan, former New Jersey Commissioner of Health, is understood to be contemplating an entry into politics in his home state, possibly running for the GOP nomination for the Senate.

Growth for Medical Products

Now passed by both Houses and awaiting conference, medical device legislation has made members of that industry predict a bullish future.

The legislation will add $250,000 to $700,000 in costs to products requiring premarket approval. The hottest medical device will continue to be the pacemaker. Sales are expected to increase at an average annual compound rate of nine per cent. Another big item is the cat (CAPS) scanner. Manufacturers predict 3,000 placements by 1980. The use of renal dialysis is expected to triple by 1980. Catastrophic or comprehensive national health insurance will also help the industry. Makers of orthopedic and surgical appliances, clinical diagnostics, medicinals, and pharmaceuticals all expect steady growth. Drug companies predict biggest growth in anti-anthritics sales.

The legislation provides three categories for devices —class I, general controls; class II, performance standards; and class III, premarket approval, the general controls give FDA authority to move against devices that are misbranded or badly-made and require their registration as if they were drugs. FDA can exempt some devices from this control, such as custom devices not intended for general sale.

Class II devices would be required to meet certain manufacturing standards.

The class III classification involves pre-market clearance for new products and essentially the same type of clearance for existing products. The House Commerce Committee report said it expected that intrauterine devices would fall in the class III category.

The Senate Labor and Public Welfare Committee has approved legislation subjecting clinical laboratories in both intrastate and interstate commerce to federal licensure and standards requirements.

The revision of the Clinical Laboratories Improvement Act (CLIA) would cover labs operating only within one state for the first time, and give HEW a stronger role in supervising the nation's clinical laboratories.

Individual physicians who perform tests solely in connection with treatment of their own patients could be exempted from the law's requirements if HEW wished.

The measure, expected to be voted soon by the full Senate, provides leeway for continuation of existing accreditation and certification programs by the Joint Commission on Accreditation of Hospitals and the College of American Pathologists (CAP). AMA and the CAP had urged Congress to allow these activities to continue.

One provision adopted by the Committee would require disclosure of fees and contractual relationships between labs and physicians using their services.

The House Commerce Subcommittee on Health is slated to start hearings soon on similar legislation.

Lowest Cost Available

The government's controversial plan to limit reimbursement for some Medicare-Medicaid drugs to the lowest cost available took effect April 26 despite opposition from pharmaceutical and medical groups and questions raised by lawmakers.

HEW Secretary David Mathews said the disputed proposal inaugurated by his predecessor, Caspar Weinberger, will be implemented on schedule. "We will never find out what will happen until we do it," Mathews said in a letter to G. Joseph Stetler, President of the Pharmaceutical Manufacturers Association (PMA).

The PMA and the AMA have filed suit against the proposed Maximum Allowable Cost (MAC) regulations. The AMA contends the plan violates patients' rights to seek the best medical care according to their physicians' best judgment in prescribing.

Rep. Daniel Flood (D-Pa.), Chairman of the House Appropriations Subcommittee on Health, recently asked Mathews "what's magic about now? The states are not ready; why can't you wait to prove the soundness of the program?"

In his letter to Stetler, Mathews said that if MAC proves detrimental to drug development or distribution, "it will be changed or dropped."

Federal administrative costs were estimated at more

than $2 million a year by Mathews. States will have to pay an initial $3 million.

Health Costs Are Prohibitive

The American health care system is due for tight government control because costs are becoming more than the economy can bear.

This was the grim message of speaker after speaker at a Washington, D.C. conference on the economic impact of health care legislation. The meeting was sponsored by Arthur D. Little, Inc., a Cambridge, Mass., consulting and research outfit.

"The cost is becoming prohibitive," declared Charles Edwards, M.D., former Assistant HEW Secretary for Health. "The U.S. health care system is headed toward fundamental changes that are certain to occur and sooner than most expect," Dr. Edwards warned. He predicted health care will cost $135 billion next year, $600 for every person in the country.

Declaring that this decade for physicians could be called the "showdown seventies," Malcolm C. Todd, M.D., Immediate Past President of the AMA told the conference of business and health leaders that he hoped for a "proper accommodation" between the medical profession and the federal government. Unless a pluralistic system is retained, Dr. Todd warned, "federally inspired chaos" could emerge.

"There could be a vivious circle . . . with programs foundering on their own shortcomings and blunders . . . and government blaming doctors and hospitals for the failures in order to justify even more repressive programs," he said.

A study was released by the Arthur D. Little firm estimating that the passage of national catastrophic health insurance would add $4.5 billion to 1980 expenditures for principal health care products and services. If no new national health coverage becomes effective, spending for health care is expected to grow at an average annual rate of four per cent over the next five years, or from $98.8 billion in 1975 to $112 billion in 1980, the study said.

Enactment of national comprehensive health insurance, which Little said is not regarded as very likely to happen before 1980, would increase health care spending by 12 per cent or $13.6 billion, for an annual total of $125.6 billion in five years.

Commenting on the study, Dr. Todd said "it confirms that any of the national health insurance programs before the Congress will result in greater utilization by patients and thus increased expenditures."

Lawrence Hill, Executive Vice President of the American Hospital Association, said that the future holds "more expenditures, rising costs, concern with those expenditures, and costs leading to attempts to control by price controls and by tinkering with the delivery system."

Hill foresaw a collision between rising costs and "capped" prices. Hospitals, he said, might have little option but to limit services. "Lines of doctors and patients will form and the hospital will patrol these, admitting as resources allow."

"The price-cost collision will cause some rationing which, in turn, will cause internal adjustments concerning how physicians use hospital facilities. The community relations implications in rationing are obvious, and, of course, at this point in time we simply do not know how to ration health care because we never have tried before." ■

OCHAMPUS SEEKS TO FILL VACANCY FOR GENERAL MEDICAL OFFICER

OCHAMPUS is accepting applications through June 4, 1976 for the position of medical officer (general) for Fitzsimons Army Medical Center, Denver, Colorado.

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Requirements. Applicants must meet one of the following requirements: 1) M.D. degree from a U.S. or Canadian medical school approval by the Council on Medical Education and Hospitals of the AMA; 2) M.D. degree from a medical school other than above, if he can satisfy through other criteria that he has acquired comparable medical knowledge. The following may be used to demonstrate this—license to practice medicine, duty as a medical officer in the U.S. military service or Public Health Service, certification by a specialty board, etc.

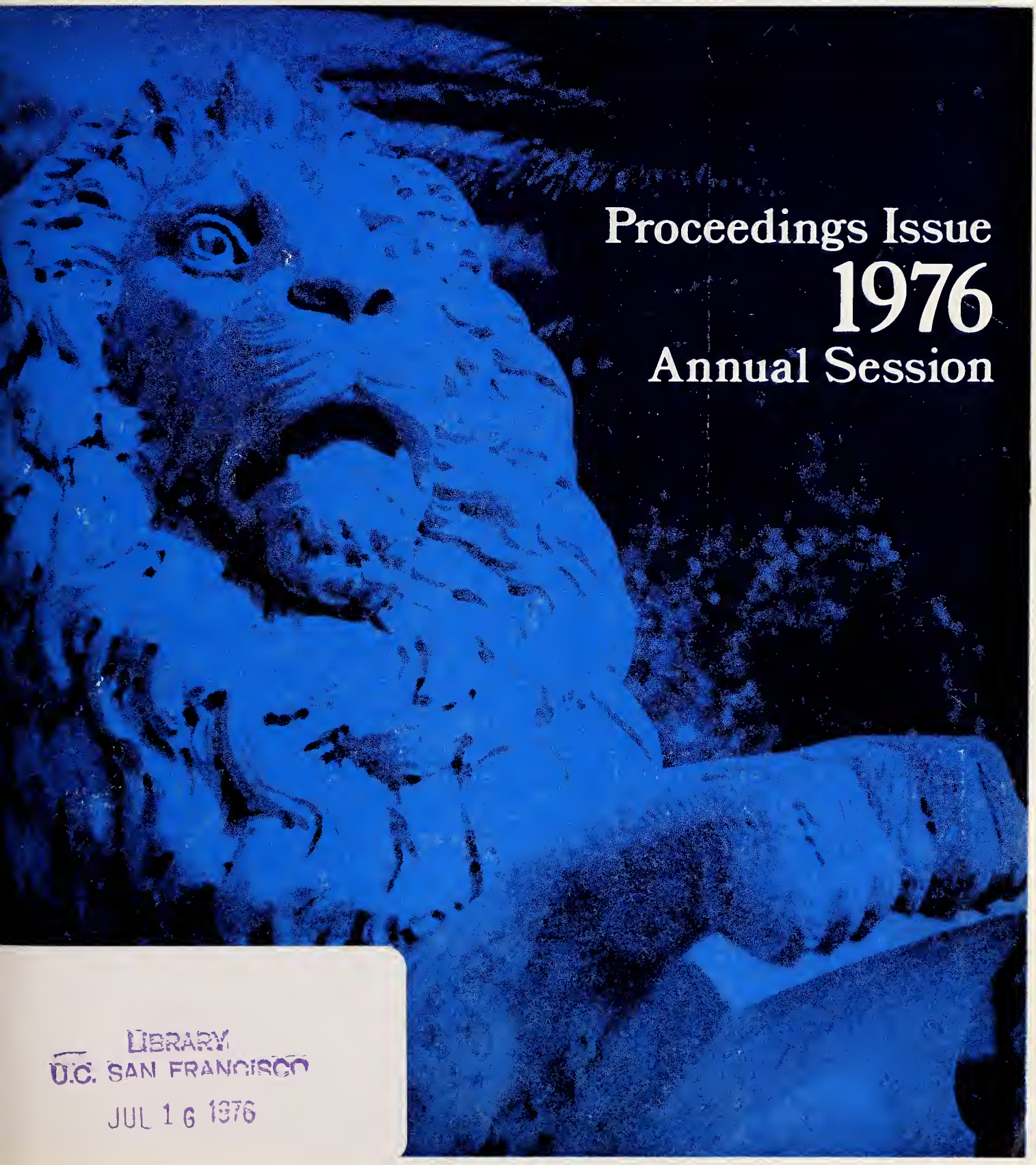
Those rated as "highly qualified" must show superior communications skills, both written and oral, knowledge of the CHAMPUS function and its relationship to other health programs; evidence of superior professional achievement such as certification by a specialty board.

Application instructions. The following application forms must be filled out: SF-171, Personal Qualifications Statement; WA-198, Supplementary Statement for Medical Officers; CSC Card Form 5001-ABC. Completed forms should be mailed to: Civilian Personnel Office, ATTN: C. Emmett, Fitzsimons Army Medical Center, Denver, Colorado 80240.

For further information, or to obtain application forms, contact Mrs. Corinne Emmett at (303) 341-3017/8614, or AUTOVON 943-3017/8614.

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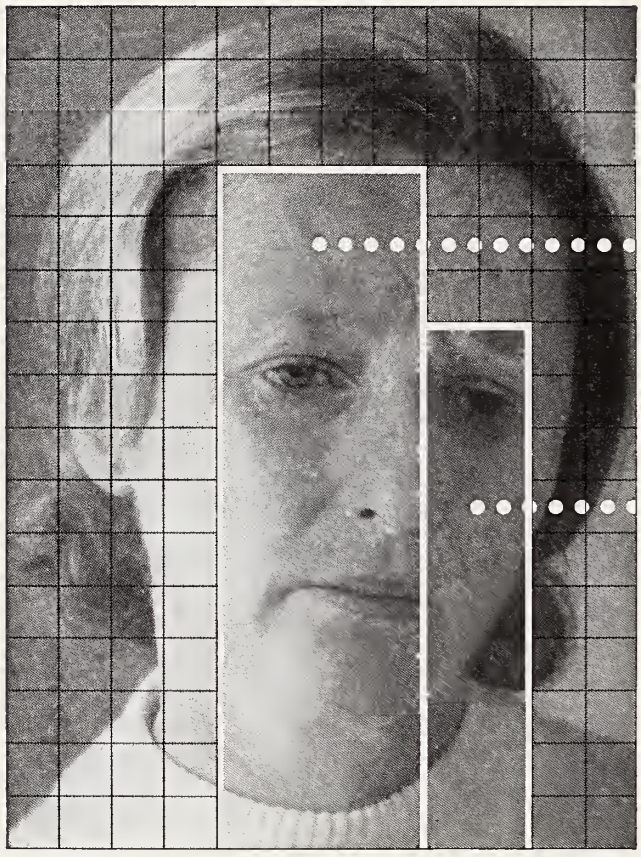
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Highlights of the 1976 Annual Session

The 1976 Annual Session of the Medical Association of Georgia was held at the Holiday Inn on Jekyll Island April 9-11, 1976. The total attendance, including delegates, members, Auxiliary and guests, was 435.

Participants at the Third Annual GaMPAC brunch heard several discussions about the organization and the need for physician involvement in political activities.

Additionally, the Association sponsored a seminar on malpractice and how to avoid litigation.

A full report of all resolutions and reports presented to the 1976 House of Delegates along with House action follows these highlights.

Awards

F. G. (Tex) Eldridge of Valdosta was presented the Distinguished Service Award; Fred P. Manget, M.D. of Macon won the Civic Endeavor Award and John A. Bell, M.D. of Dublin was the recipient of the Family Physician of the Year Award. Additionally, James A. Kaufmann, M.D. of Atlanta was given special recognition for his outstanding efforts in various legislative activities on behalf of the Association.

Officers

Fleming L. Jolley, M.D. of Atlanta was installed as President, David A. Wells, M.D. of Dalton as Immediate Past President and Robert E. Perry, M.D. of Brunswick as President-Elect. Other officers either installed or elected were: James H. Sullivan, M.D. of Columbus as First Vice President; Milton I. Johnson, M.D. of Macon as Second Vice President; Harrison L. Rogers, M.D. of Atlanta and J. Daniel Bateman, M.D. of Albany succeeding themselves as delegates to the AMA; and H. Hilt Hammett, M.D. of LaGrange and William W. Moore, M.D. of Atlanta as alternate AMA delegates.

Special House elections for Third District representatives were held, and the position of Councilor was filled by John H. Robinson of Americus and Vice Councilor by B. Lamar Pilcher of Warner Robins.

National Health Insurance

The House reviewed and passed a resolution placing the Association in opposition to any form of national health insurance. The resolution, from the DeKalb County Medical Society, calls for the MAG delegation to the AMA House of Delegates meeting to introduce another resolution directing the AMA to conduct an all member opinion survey asking if the members are in favor of national health insurance and if the AMA should sponsor a national health insurance proposal. If survey results show majority opposition to NHI, the resolution directs the AMA to withdraw its legislative proposal.

Unified Membership

A new policy was adopted by the House directing unified membership between the component county medical societies and the MAG. In adopting the plan, the House took note of the fact that it was never intended that a county society, chartered by the state organization, should have members that were not also members of MAG. The unified membership procedures will begin with the 1977 issuance of dues statements.

Dues Schedule

A graduated dues structure was approved by the House, hopefully to increase the interest and in-

volvement of younger physicians. The structure will allow new physicians to pay one third of the total dues for first year membership, two thirds for second year and the full dues amount the third year. This system will not be used for members rejoining MAG or those coming to Georgia from other states.

The House also approved a new dues structure for older physicians. If a physician has been a member at least 10 years and has attained the age of 66 he will be given a 20 percent reduction in dues. He will receive additional 20 percent reductions each year until age 70, when he is eligible for life membership status.

Dues Increase

The House voted to increase membership dues from $100 annually to $225 annually. Reasons given for the dues increase include: removal of a deficit in the approved budget; to provide needed funds for increased legal expenses in anticipation of more aggressive activity in that area; and placement of the Association in a posture that would allow less dependence on financial assistance from governmental agencies.

Equalization of Fees

The House adopted a resolution from the Subcommittee on Rural Health that calls for physicians to receive like fees for like service delivered without regard to geographic location. The House took note that an equalization of the fee reimbursement structure would serve as an added incentive for physicians considering practice in rural areas.

Future Meetings

The dates and sites of future Annual Business Sessions are:

1977 (April 22-24) Macon
1978 (April 21-23) Augusta
1979 (April 20-22) Savannah
1980 (dates undecided) Atlanta

SCIENTIFIC EXHIBITS

The Planning Committee for the 1976 MAG Scientific Assembly is accepting a limited number of applications for non-commercial scientific exhibit space. The meeting will be held November 19-20 at the Omni International Hotel in Atlanta.

Deadline for receipt of applications is September 1, 1976. Application forms may be obtained by writing to Stephen L. Daniel, MAG, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

JOURNAL
of the medical association of
georgia

MAG First General Session

1976 Annual Session Business Meeting
Friday, April 9, 1976

THE FIRST GENERAL SESSION of the 1976 Annual Business Meeting (House of Delegates) of the Medical Association of Georgia was called to order by President David A. Wells, M.D. of Dalton at 9:10 a.m. in Colony Hall at the Holiday Inn on Jekyll Island, April 8, 1976.

Dr. Wells extended an official welcome to all present and called upon the Reverend Carlton Carruth, pastor of the First Methodist Church of Brunswick, for the invocation. Following the invocation, those attending the General Session remained standing for the playing of the National Anthem.

President Wells called on Earnest C. Atkins, M.D., MAG Secretary, to read the names of the MAG members who had died since the 1975 Annual Session. They are as follows:

MAG Deceased Members

James K. Adams, Jefferson, May 16, 1975
A. J. Aselmayer, Rome
C. L. Ayers, Toccoa, Aug. 5, 1975
George W. Barker, Jr., St. Marys, Sept. 25, 1975
Hartwell Boyd, St. Simons Island, Sept. 29, 1975
H. B. Bradford, Cartersville, Nov. 14, 1975
Pierpont F. Brown, Jr., Gainesville, March 8, 1976
Richard Brown, Marietta, Feb. 12, 1976
C. H. Bryant, Comer, Aug. 2, 1975
V. L. Bryant, Wadley
James H. Byram, Atlanta, Jan. 25, 1976
William E. Campbell, Jr., Atlanta, March 31, 1975
Olin S. Cofer, Atlanta, June 31, 1975
P. L. Collinsworth, St. Augustine, Fla., June 16, 1976
R. Dale Cooper, Atlanta, Aug. 11, 1975
W. J. Cranston, Augusta, 1972
C. E. Cunningham, Decatur, June 19, 1975
Wilson T. Edenfield, Atlanta, March 6, 1976
Ivan R. Elder, Bremen, Feb. 28, 1976
Thomas F. Eyres, Vermillion (S.D.), Mar. 19, 1975
Thomas D. Goodwyn, Atlanta, Sept. 14, 1975
O. T. Gower, Jr., Cordele, Oct. 30, 1975
John I. Hall, Macon, July 13, 1975
W. W. Hamilton, Augusta
Samuel J. Hightower, Macon, Nov. 1, 1975
Walter R. Holmes, Atlanta, June 11, 1975
Simon Krantz, Atlanta, March 14, 1976
John R. Lewis, Sr., Louisville, Sept. 1, 1975
Guy G. Lunsford, Atlanta, Feb. 27, 1976
George Massenberg, Macon, March 14, 1976
W. A. Mendenhall, Chamblee, March 3, 1976
William R. Minnich, Atlanta, Dec. 18, 1975
Nathan J. Newsom, Sandersville, Oct. 10, 1975
Samuel W. Norwood, Atlanta, March 4, 1976
S. T. Parkerson, McRae, April 3, 1975
Walter O. Pendley, Rome, July 13, 1975
Edgar R. Pund, Seneca, S.C.
Stephen C. Redd, Atlanta, Dec. 2, 1975
J. A. Redfearn, Albany, Oct. 1, 1975
Charles H. Richardson, Sr., Macon, Jan. 3, 1976
Robert C. Robbins, Marietta, Feb. 12, 1976
Robert L. Rogers, Gainesville, June 1, 1975
Frank H. Sams, Reynolds, Dec. 16, 1975
B. L. Shackleford, Atlanta, May 1, 1975
H. F. Sharpley, Savannah, Nov. 30, 1975
William G. Simmons, Sylvania, Oct. 7, 1975
Fred Simonton, Chickamauga, Dec. 7, 1975
Eugene Spier, Atlanta, Dec. 4, 1975
H. B. Stillerman, Atlanta, May 19, 1975
Richard Torpin, Augusta, Feb. 6, 1976
Frank Weitz, Atlanta, Feb. 14, 1976
Robert L. Whipple, Jr., Atlanta, Nov. 23, 1976
John G. Wilmer, Atlanta, Feb. 18, 1975
J. T. Wright, Thomasville

Following the memorial service, Dr. Wells introduced Richard W. Egan, M.D., President of the

Glynn County Medical Society, who extended greetings from the host medical society to the Assembly. President Wells introduced several distinguished guests: C. Tucker Weston, M.D., President, South Carolina Medical Association, and Mrs. Weston; Mr. Edward J. Fechtel, Jr., President, Georgia Hospital Association; Mr. Ed Bond, President, Georgia Health Care Association; Mrs. Betty Golden, President, Georgia Nurses Association; Mr. Frank Riley, Mr. James E. Thompson, and Mr. Robert Thompson, representing Blue Cross-Blue Shield of Columbus; and Mrs. Patricia Leet, Director of the Georgia Comprehensive Health Planning.

At this point Dr. Wells introduced Mrs. Phil C. Astin, Jr., President to the Auxiliary to the Medical Association of Georgia. Mrs. Astin made a brief report on the activities of the Auxiliary and introduced a special guest, Mrs. Norman H. Gardner, President-elect of the Woman's Auxiliary to the American Medical Association. Mrs. Gardner extended greetings from the AMA Auxiliary and gave a brief report on the activities of the AMA Auxiliary.

Presentation of Awards

Dr. Wells presented the two Georgia medical schools unrestricted grant monies in the form of an AMA-ERF check raised by contributions from the physicians and Auxiliary during the previous year. Dr. Wells presented the checks as follows: to Dr. Fleming L. Jolley, accepting on behalf of Dean Arthur Richardson, of the Emory University School of Medicine, a check in the amount of $8,399.34; to Dr. Charles H. Wray, on behalf of the Medical College of Georgia, a check in the amount of $6,373.66.

Family Physician of the Year Award

MAG presents an annual award to the Family Physician of the Year and calls upon the Board of Directors of the Georgia Academy of Family Physicians (GAFP) to select the recipient of this award.

Dr. Wells asked Wells Riley, M.D., President of the GAFP, to present the award this year. Dr. Riley announced that the 1976 recipient was John A. Bell, M.D. of Dublin. The award was presented to Dr. Bell who gave a brief response.

Fifty Year Pins and Certificates

Dr. Wells called upon J. Rhodes Haverty, M.D., to read the list of recipients of the MAG 50 Year Pins and Certificates. They were: Henry H. Allen, Decatur; Harold C. Atkinson, Macon; Hubert H. Blanchard, Barnesville; F. Bert Brown, Atlanta; Loree Florence, Athens; John D. Martin, Jr., Atlanta; Keith C. Rice, Clayton; J. Victor Roule, Augusta; Carter Smith, Atlanta; William A. Smith, Atlanta; J. W. Thurmond, Augusta; George L. Walker, Griffin, and George W. Wright, Augusta.

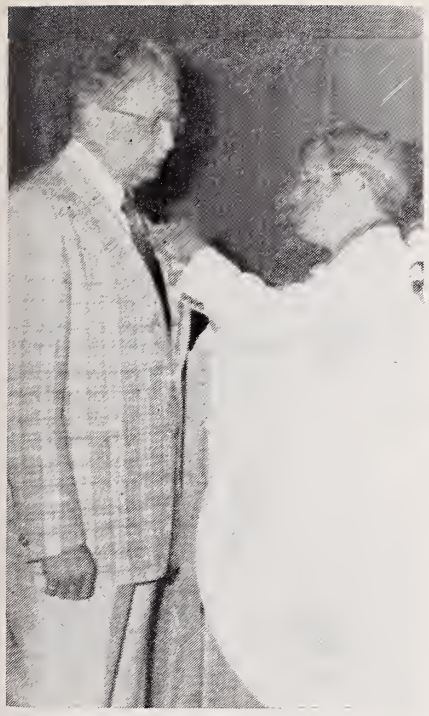
Life Membership

President Wells read the names of the recipients of the gold membership card, signifying life membership in MAG. They are the following: W. O. Bedingfield, Savannah; J. M. Byne, Jr., Waynesboro; F. G. Eldridge, Valdosta; Henry Gall, Cairo; John L. Jacobs, Atlanta; H. P. McDonald, Atlanta; James W. Reed, Thomasville; Charles Stephenson, Ringgold; William G. Talbert, Warner Robins; Harold P. Taylor, Sea Island; and W. E. Upchurch, Atlanta.





Distinguished representatives from the American Medical Association attend MAG's Annual Session. President Max H. Parrott, M.D. (L) of Portland, Ore. tells the delegates the AMA is becoming more "aggressive" and has "moved to new heights in its responsiveness" to the needs of its members. President-elect of the AMA Auxiliary, Mrs. Norman H. Gardner (R) of East Hampton, Conn. is introduced by Mrs. Phil C. Astin of Carrollton, outgoing president of the MAG Auxiliary.



Selected as Family Physician of the Year is John A. Bell, M.D. of Dublin, congratulated by Wells Riley, M.D., President of the Georgia Academy of Family Physicians. Dr. Bell is a graduate of the Medical College of Georgia and recently became chairman of the University System Board of Regents.



Winner of the 1976 Civic Endeavor Award is Fred Prosper Manget, of Macon. Dr. Manget, 96, has a long record of service to the elderly and needy. As a young doctor, he worked in the China mission fields; at age 60 he opened a free clinic for the poor in Atlanta; and in 1974, Dr. Manget began a clinic in Macon for needy senior citizens.



The highest honor of the Association, the Distinguished Service Award, is presented by President Wells to F. G. "Tex" Eldridge of Valdosta. Dr. Eldridge has strengthened and supported the Association in many ways, as president, chairman of Council, delegate, councilor and chairman of the Finance Committee.

Certificates of Appreciation

President Wells called on Carson B. Burgstiner, M.D., Treasurer, to read the names of the recipients of the Certificates of Appreciation as follows: Mrs. Phil C. Astin; John S. Atwater; John G. Bates; Lee H. Battle, Jr.; Hon. Wilbur E. Baugh; J. W. Chambers; L. T. Crimmins; Hon. W. W. Fincher; G. Lester Forbes; Hon. Ed Garrard; George F. Green; Lovic W. Hobby; Fleming L. Jolley; W. Dan Jordan; Miriam Janet Judson, R.N.; Hon. E. Roy Lambert; Hon. W. W. Larsen; John T. Mauldin; John R. McCain; LaMar S. McGinnis; George E. Mixon; Elton S. Osborne; Thomas A. Sappington; Hon. Wayne Snow, Jr.; Hon. Thomas R. Taggart; G. Douglas Talbott; Luther M. Vinton, Jr.; Charles B. Watkins, and David A. Wells.

Civic Endeavor Award

The Civic Endeavor Award is a special award designed to honor those physicians active in civic affairs. The recipient of the award is selected by a secret committee which evaluates nominations made by the county medical societies. Dr. Wells called upon Fleming L. Jolley, M.D., President-Elect, who announded that the recipient of the Civic Endeavor Award is Fred P. Manget, M.D., of Macon.

Distinguished Service Award

The highest honor that the Medical Association of Georgia can bestow upon one of its members in recognition of service to the Association is the Distinguished Service Award. At this point President Wells announced that the recipient of the 1976 Distinguished Service Award was F. G. Eldridge, M.D., of Valdosta.

Guest Speaker

Dr. Wells introduced Max H. Parrott, M.D., Portland, Oregon, President of the American Medical Association, who addressed the First General Session of the 1976 MAG Annual Session. Following Dr. Parrott's remarks, President Wells made several brief announcements and adjourned the First General Session at 10:35 a.m.

First Session House of Delegates

Friday, April 9, 1976

THE FIRST SESSION of the House of Delegates was called to order by Speaker L. C. Buchanan at 10:35 a.m. in Colony Hall, Holiday Inn, Jekyll Island, on Friday, April 9, 1976. The Speaker extended his greetings to all delegates and briefly outlined the responsibilities of the House and the procedures to be followed during the two sessions of the House on April 9 and April 11, 1976.

Speaker Buchanan called for a report of the delegates in attendance. Frank R. Miller, M.D., Thomasville, Chairman of the Credentials Committee, reported that there were 148 registered delegates representing 41 component societies, and accordingly announced that a quorum of the House was present.

Attendance

Stanley P. Aldredge, Joseph M. Almand, Jr., Thomas J. Anderson, Jr., Jimmy R. Asbell, Phil C. Astin, Jr., J. Dan Bateman, John G. Bates, Robert L. Bennett, Joseph N. Berry, James S. Bethea, III, H. Duane Blair, Franklyn P. Bousquet, Jr., William L. Bowen, Jr., Claud A. Boyd, Jr., David M. Boyette, Charles K. Bradley, Rupert H. Bramblett, Rodney M. Browne, L. C. Buchanan, Carson B. Burgstiner.

Ted D. Cash, Joseph T. Christmas, Spurgeon William Clark, Jr., Robert P. Coggins, Marvyn D. Cohen, Richard W. Cohen, William C. Collins, Leon E. Curry, David E. Dalrymple, Floyd E. Davis, H. G. Davis, Jr., J. H. Deaton, F. W. Dowda, Fred J. Duhon, John G. Etheridge, E. C. Evans, Louis H. Felder, Lucien A. Flint, Henry A. Foster, Whitman Fraser, Lawrence L. Freeman.

Ronald Frost Galloway, John W. Garland, III, Cyler D. Garner, Frank L. Gibson, Michel A. Glucksman, Milton S. Goldman, Walter S. Gresham, Richard A. Griffin, III, Warren L. Griffin, Jr., Oscar Emerson Ham, H. Hilt Hammett, Jr., Timothy Harden, Jr., Charles E. Harrison, Jr., Clyde C. Harrison, Jr., James H. Harrison, John Rhodes Haverty, Katrine R. Hawkins, John P. Heard, E. V. Herrin, Charles F. Hobby, Charles D. Hollis, Jr., William R. Howard, William Huger, Jr., J. R. B. Hutchinson.

W. Scott James, Jimpsey B. Johnson, Julius T. Johnson, Frank M. Johnston, Fleming L. Jolley, W. Daniel Jordan, James A. Kaufmann, James A. Kibler, C. Peter Lampros, Bob G. Lanier, James H. Larose, James Moultrie Lee, James R. Logan, William Dewey Logan, Jr., Daniel R. Luke.

Bob R. Maughon, Stephen C. May, Jr., Edwin A. Mayo, John R. McCain, John N. McClure, William E. McDavid, Jr., James K. McDonald, Charles W. McDowell, Jr., V. W. McEver, Jr., Ollie O. McGahee, Jr., LaMar S. McGinnis, Jr., Donald J. McKenzie, Jack R. Meacham, Jack F. Menendez, Cecil L. Miller, Frank R. Miller, George D. Miller, Edmund M. Molnar, W. W. Moore, Christian R. Moorhead, Hugo S. Moreno, R. J. Moye, Joseph A. Mulherin, A. D. Muse, Jr., James S. Myers.

D. A. Nash, Harvey M. Newman, Edmund M. Nicholas, Evans J. Nichols, Joseph J. Nichols, Robert W. Oliver, Jr., John B. O'Neal, III, James J. Oosterhoudt, W. John O'Shaugnessey, J. Gary Palmer, Jr., J. Lee Parker, J. K. Quattlebaum, Harold S. Ramos, Charles J. Rey, Jr., Charles R. Richardson, Harrison L. Rogers, Jr., T. A. Sappington, J. K. Schellack, Don Schmidt, Henry D. Scoggins, Charlie O. Sennett, Jr., Robert W. Simmons, James M. Skinner, James H. Smith, Luther J. Smith, II, Patton P. Smith, R. L. Smith, Robley D. Smith, Thomas H. Smith, Jr., William Jackson Smith, Dan B. Stephens, Joe C. Stubbs, James H. Sullivan, Robert F. Sullivan.

Luther M. Thomas, Jr., Thomas L. Tidmore, Jr., Ralph A. Tillman, Charles E. Todd, Jr., William A. Travejo, John P. Tucker, L. Newton Turk, III, Charles R. Underwood, R. J. Van de Wetering, Roy W. Vandiver, Bozidar F. Voljavec, Walter R. Voyles, Edward J. Waits, Robert D. Waller, William C. Waters, III, H. E. Weems, Jr., John A. Wells, Thomas E. Whitesides, Jr., Douglass G. Whitney, J. S. Wilson, Homer P. Wood, Edgar Woody, Jr., Charles H. Wray.

Speaker Buchanan thanked the Chairman of the Credentials Committee for his report; he then presented Ronald F. Galloway, M.D., Augusta, Vice Speaker of the House and then explained in some detail the procedures to be followed for the consideration of business that would come before the House of Delegates.

Appointment of Committees

The Speaker announced the appointment of the House of Delegates Credentials Committee and Tellers Committee as follows:

CREDENTIALS COMMITTEE: Frank R. Miller, Thomasville, Chairman, Douglass G. Whitney, Atlanta; Julius T. Johnson, Augusta.

TELLERS COMMITTEE: Ralph A. Tillman, Decatur, Chairman; James Smith, Rome; Hugo S. Moreno, East Point; Charles J. Rey, Marietta.

The Speaker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: Charles W. McDowell, Jr., Decatur, Chairman; O. E. Ham, Savannah, Vice Chairman; William C. Arwood, Pelham; Claud A. Boyd, Augusta; Charles H. Durden,

Fitzgerald; William J. Smith, Brunswick.

REFERENCE COMMITTEE B: Daniel B. Stephens, Marietta, Chairman; H. Hilt Hammett, Jr., LaGrange, Vice Chairman; Joseph T. Christmas, Vienna; Don Schmidt, Cedartown; Lawrence Freeman, Chamblee; David M. Boyette, Albany.

REFERENCE COMMITTEE C: Kenneth McDonald, Augusta, Chairman; Charles R. Richardson, Statesboro, Vice Chairman; Charles F. Hobby, Valdosta; Whitman Fraser, Hinesville; James A. Kaufmann, Atlanta; Roy W. Vandiver, Decatur.

REFERENCE COMMITTEE D: Jack S. Menendez, Macon, Chairman; Louis H. Felder, Atlanta, Vice Chairman; Walter R. Voyles, Waynesboro; Daniel R. Luke, Gainesville; R. J. Moye, Swainsboro; Joseph M. Almand, LaGrange.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS: Robert W. Oliver, Dublin, Chairman; Michel A. Glucksman, Brunswick, Vice Chairman; Frank Johnston, Savannah; Joe S. Wilson, Atlanta; John P. Heard, Decatur; E. Van Herrin, Athens.

REFERENCE COMMITTEE F: H. Duane Blair, Decatur, Chairman; James H. Sullivan, Columbus, Vice Chairman; William G. Huger, Jr., Atlanta; Charles H. Wray, Augusta; W. John O'Shaughnessey, Macon; Franklyn P. Bousquet, Jr., Savannah.

The Speaker announced that the proceedings of the 1975 Annual Session had been published in the June, 1975, issue of the *Journal of the Medical Association of Georgia,* and called for any corrections that should be made. There were none and he called for a motion for approval of these proceedings as published. On motions duly made and seconded it was voted that these minutes be approved as published.

Nominations

Speaker Buchanan called on the House to proceed with the nominations of officers, AMA Delegates and Alternates, Councilors and Vice Councilors. He reminded the House that the election would be held on Sunday morning with voting hours between 7 a.m. and 9:30 a.m., with ballots being provided by the Credentials Committee.

The Speaker asked for nominations for the office of MAG President-Elect and the following nomination was made.

PRESIDENT-ELECT: Robert E. Perry, Brunswick, nominated by Michel A. Glucksman. Dr. Perry's candidacy was seconded by F. G. Eldridge. There being no further nominations for the office of President-Elect, the nominations were closed.

SECOND VICE PRESIDENT: Leon E. Curry, Metter, was nominated for the office of Second Vice President by Charles Todd. Dr. Curry's candidacy was seconded by Frank Robbins, Julian Quattlebaum, Edwin Allen, Charles Richardson and Charles Underwood.

Milton I. Johnson, Macon, was nominated for the office of Second Vice President by Jack Menendez. Dr. Johnson's candidacy was seconded by T. A. Sappington, James Smith, Daniel Jordan, H. Hilt Hammett, and C. E. Bohler.

There being no further nominations for the office of MAG Second Vice President, the nominations were closed.

AMA DELEGATES: Speaker Buchanan called for nominations for delegates to the American Medical Association. He observed that the terms of all new delegates would begin on January 1, 1977.

For the office held by Harrison L. Rogers, Atlanta, Harrison L. Rogers was nominated by Newton Turk and seconded by Jack Menendez.

There being no further nominations for this office, the nominations were closed.

For the office held by J. Daniel Bateman, Albany, J. Daniel Bateman was nominated by Joe Stubbs and seconded by James A. Kaufmann.

There being no further nominations for this office, the nominations were closed.

The Speaker asked for nominations for the office of Alternate Delegate to the American Medical Association.

AMA ALTERNATE DELEGATE: For the office held by H. Hilt Hammett, Jr., LaGrange, H. Hilt Hammett, Jr., was nominated by Joseph Almand and seconded by T. A. Sappington, Charles Todd, and Carson Burgstiner.

There being no further nominations for this office, the nominations were closed.

For the office held by W. W. Moore, Jr., Atlanta, W. W. Moore, Jr., was nominated by J. Harold Harrison and seconded by Harvey Newman, Thomas Tidmore, Edmund M. Molnar, and Charles Underwood.

Luther Vinton, Decatur, was nominated by LaMar McGinnis and seconded by Julius Johnson (for himself and on behalf of Stuart Prather), Don Schmidt and Daniel Jordan.

There being no further nominations for this office, nominations were closed.

Councilors and Vice Councilors

Speaker Buchanan announced that the Third Councilor District had not elected their Councilor and Vice Councilor according to Chapter V, Section 2 of the Bylaws as their annual meeting had not been held prior to the Annual Session. Accordingly he announced that the election of the Third District Councilor would be done by the House of Delegates pursuant to the Bylaws.

The Speaker then recognized Fleming L. Jolley

for the purpose of nominating a candidate for the office of Third District Councilor and Vice Councilor. Dr. Jolley nominated John H. Robinson, Americus, for Councilor and B. Lamar Pilcher, Warner Robbins, Vice Councilor. Nominations were seconded by James Sullivan. There being no further nominations for the office of Third District Councilor and Vice Councilor, the nominations were closed.

Dr. Buchanan announced the results of the election for Councilor and Vice Councilor as conducted by the component medical societies. These were:

First District Councilor, Leon Curry, Metter (1979); Vice Councilor, Charles R. Richardson, Statesboro (1979).

Second District Councilor, J. Dan Bateman, Albany (1979); Vice Councilor, Sammie Dixon, Tifton (1979).

Medical Association of Atlanta Councilor, T. J. Anderson, Atlanta (1978), and J. Harold Harrison, Atlanta (1979); Vice Councilor, William D. Logan, Atlanta (1978), and William C. Waters, III, Atlanta (1979).

Georgia Medical Society Councilor, Joe A. Mulherin, Savannah (1979); Vice Councilor, Joe L. Nettles, Savannah (1979).

Annual Reports

Speaker Buchanan called for the Annual Reports of MAG officers, councilors, committees and other reports to be introduced at this session which are listed below with the reference committee to which these reports were referred appropriately indicated. (Editorial note: Each complete report, the action of the Reference Committee and the subsequent action taken by the House of Delegates on all reports referred to a Reference Committee will be found under the proceedings of the Second Session of the House of Delegates. See pages 198-261.)

OFFICERS

President—Reference Committee A
President-Elect—A
Immediate Past President—Constitution and Bylaws
First Vice President—A
  Supplemental Report—F
Second Vice President—Not Referred.
Council
  Chairman—A
  Supplemental (Budget)—F
  Supplemental—all reference committees
  Supplemental (PSRO)—B
  Supplemental (Peer Review Mechanism)—B
Secretary
  Membership—A
  Annual Report—Not Referred
  MAG Benevolent Foundation—F
  GMCF—F
  Headquarters Office—F
  Osteopathic Physicians—D
  Membership Insurance—B
  Continuing Medical Education—D
  Membership Dues—F
Treasurer—F
Speaker—Not Referred
AMA Delegation—A

COUNCILORS

First District—Not Referred
Second District—Not Referred
Third District—Not Referred
Sixth District—Not Referred
Seventh District—Not Referred
Eighth District—Not Referred
Ninth District—Not Referred
Tenth District—Not Referred
Bibb County—Not Referred
Cobb County—Not Referred
DeKalb County—Not Referred
Floyd-Polk-Chattooga—Not Referred
MAA—Not Referred
Georgia Medical Society—Not Referred
Muscogee County—Not Referred
Richmond County—Not Referred

ASSOCIATION COMMITTEES

Access to Health Care—Reference Committee B
  Supplemental—B
  Subcommittee on Rural Health—Not Referred
  Supplemental—B
Allied Health—Not Referred
Cancer—Not Referred
  Supplemental—D
Communications
  Recommendation 1—D
  Recommendations 2-5—A
Constitution and Bylaws—Constitution and Bylaws
Education—Not Referred
  Continuing Medical Education—D
  Education Coordinator—D
Emergency Medical Services—Not Referred
Laboratory Quality—A
Maternal and Infant Health—C
Medical Aspects of Sports—Not Referred
Medical Practice—B
  Resolution 9-75—B
Membership Insurance—B
Mental Health—A
National Legislation—C
Nursing—D
Occupational Health—Not Referred
Organization and Functions—Constitution and Bylaws
Prison Health Care—Not Referred

Professional Conduct and Medical Ethics—A
Public Health—D
Scientific Assembly—D
State Institutions—Not Referred
State Legislation—C
Third Party Relations—B
Liaison to Board of Human Resources—C
Liaison to Georgia State Medical Association—A
Osteopathic Liaison—D
Physician-Lawyer Liaison—Not Referred
Ad Hoc Committee on Organization and Functions —Constitution and Bylaws
Ad Hoc Committee on Physician's Assistants—D
Review by Milton Johnson—D
Ad Hoc Committee on Transfusions and Transplantations—Not Referred
Disabled Doctors Program—A
Interspecialty Council—Not Referred

REPORTS OF DEPARTMENTS

Georgia Regional Medical Program—Not Referred
Georgia Medical Care Foundation—B
Research and Development—Not Referred
Auxiliary to MAG—A
Journal MAG—Not Referred

The Speaker called attention to the reports which are shown as having no recommendations and thus have not been referred to any reference committee. He called upon the delegates to request referral of any report they desire to see go to a reference committee. The Speaker then announced that all reports not referred to reference committee would be filed for information. They are as follows:

SECOND VICE PRESIDENT

James H. Sullivan, M.D.

It has been a privilege and an honor to serve the Medical Association of Georgia during the year 1975-1976 as your Second Vice President. Without the staff of the Medical Association of Georgia, it would be impossible for any officer to function in his duties. And it has been a privilege to serve with my fellow physicians, to broaden my knowledge, and to help conduct the business of the Medical Association of Georgia.

I became involved and ran for this office for several reasons. One, to become involved in the ordinary business of the Medical Association of Georgia. I believe that at least 90 per cent of our fellow physicians in the MAG wish to become involved, in either mechanisms for peer review, to utilization review, to committee function, to investigation and solution of the many problems which we in organized medicine are facing every day, with more on the horizon.

I became involved in this office for another very important reason and that was that I did not believe communication was as it should have been. Communication from the officers of the MAG, the House of Delegates, the Council of the MAG, the Executive Committee to the county and district societies and thence to the practicing physician is a necessity. One of the most important things that has come about this year with the proding and help of the membership and the staff has been the beginning of the MAG newsletter which is at the present a monthly publication, but we hope could be a weekly publication as the main line channel of communication from the AMA and MAG to the practicing physician. Many people have helped begin this project.

I became involved in this office for another reason, that of taking a moderate view going into a situation without ones mind made up pro or con, and then on the merits of the situation make a decision. I think this is important because we have to have a stable outlook to handle such huge diverse problems as PSRO, malpractice legislation, HMO concepts, legal ramifications of lawsuits, disabled doctors programs and many of the day to day problems that arise in such a large and active association as the MAG provides its membership.

I think the office of Second Vice President is a good starting point for learning and ramifications of the MAG, and in spite of what has been said before, it makes no difference whether the Second Vice President has a vote in the Executive Committee, the fact that he can discuss issues and come before the Executive Committee and that he is a voting member of the Council of the MAG is extremely important. We need to get more of our physicians involved, whether it be involvement in the active participation of Council, House of Delegates, or whether it be work on the numerous committees which are active in our MAG. I believe any of our fellow physicians who want to have input into committee work or MAG work should be invited to attend any meeting or become an ex officio member of any committee. It is extremely interesting that in our local county society a post card was sent to each member of our society asking the membership to please check an activity in which they would most like to be involved. We had an almost 75 percent response from this mailing. The interest was in the various fields of public health and preventive medicine, communications and public relations, legislation, professional liability and insurance, health service area, Georgia Regional Medical Program work, Medical Care Foundation and peer review, PSRO committee, Medicare and Medicaid problems, auxiliary advisors, maternal and infant welfare, and continuing medical education. Ten of our own physicians also volunteered for any state and local or other committee function where they could be of service.

I think the most important thing that came out of our national AMA leadership conference was the phrase, "keep moving." I think this also applies to our local medical societies, our Medical Association of Georgia and the AMA. There are so many diverse problems facing us every day that we must become active and we must become involved so that we may keep moving.

The danger of the present is the danger of complacency and apathy and we must maintain our patient-physician relationship, our system of free enterprise, with the fee for service and free choice of physician and patient. We must remember that medicine must continue its quality control review mechanism as opposed to government imposed cost control of the practice of medicine. There are no recommendations to be

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
GEORGIA
1974-1975 STATISTICAL REPORT

Claim Flow	Annual 1974	Annual 1975	Percent of Total 1974	Percent of Total 1975	Percent of Annual Change (1973-74)	Percent of Annual Change (1974-75)
I. Number Claims Received						
1. Inpatient	32,933	40,210	35.0	33.7	15.9	22.1
2. Outpatient	49,427	64,244	52.5	53.9	28.5	30.0
3. Handicap	624	210	.7	.2		(66.3)
Subtotal	83,002	104,664	88.2	87.8	24.1	26.1
4. Drugs (Vendor & Reimbursement)	11,156	14,471	11.8	12.2	14.5	29.7
Total	94,140	119,135	100.0	100.0	22.9	26.6
II. Claims Processed						
1. Returned	11,018	15,398	13.4	12.9	13.6	39.7
2. Rejected	11,403	19,414	13.9	16.3	23.6	70.3
3. Review Committee	60	149	.1	.1	(28.6)	148.3
4. Paid						
a. Inpatient-Outpatient	51,108	72,007	62.1	60.4	6.8	40.9
b. Handicap	673	218	.8	.2	(23.3)	67.6
c. Drugs (Vendor & Reimbursement)	7,976	12,011	9.7	10.1	10.6	50.6
Subtotal	59,757	84,236	72.7	70.7	6.8	41.
Total No. Claims Processed	82,238	119,197	100.0	100.0	9.7	44.9
III. Funds Disbursed						
1. Regular (Inpatient & Outpatient)	$5,139,043.10	$6,860,044.51	90.8	93.0	8.3	33.5
2. Handicap	249,000.90	96,359.98	4.4	1.3	(21.7)	(61.3)
3. Drugs	274,024.13	424,223.99	4.8	5.7	20.7	54.8
Total	$5,662,068.13	$7,380,628.48	100.0	100.0	7.5	30.4
IV. Average Disbursements Per Claims						
1. Regular	$ 100.55	$ 95.27			1.4	(5.3)
2. Handicap	369.99	442.02			2.7	19.5
3. Drugs	34.99	35.32			2.0	.1
Total	$ 94.75	$ 61.92			.23	(34.6)

made from this office at the present time and I would again like to thank the membership of the MAG for electing me and having the opportunity to serve and become involved.

I would like to emphasize again the necessity for all of us to become active, to become involved, and to "keep moving."

SECRETARY

Earnest C. Atkins, M.D.

MAG SERVICES, INC.

Although this is MAG's newest program, the effectiveness of the print shop has proven it to be invaluable. There is both time and money saved in printing the Newsletters, all member mailings as well as your House of Delegates Handbook. You must appreciate the quality of this work.

Also, MAG members can get their printing; such as stationery, prescription pads, etc., printed on short notice and at a considerable financial saving.

The printing will underwrite the cost of this endeavor and then we can expand this operation into other membership benefits.

GEORGIA REGIONAL MEDICAL PROGRAM

There will be a separate report to the House of Delegates by Dr. Luther M. Vinton, Coordinator of the Regional Medical Program. As GRMP is phased out, J. Gordon Barrow, M.D., is widely recognized as the most outstanding director of the RMPs in the United States. We are all indebted to Dr. Barrow for his nine years in this capacity, and we realize and appreciate his dedication.

CHAMPUS PROGRAM

The MAG CHAMPUS Program continues to expand as shown in the attached report. Joyce Butler, R.N., CHAMPUS Administrator and her staff are to be commended. The Department of Defense, as well as the physicians and patients, definitely benefit from this MAG program.

SPEAKER OF THE HOUSE OF DELEGATES

L. C. Buchanan, M.D.

The Speaker at all times should, in my judgement, uphold the principles and policies, and seek to effect implementation of those mandates and directives, espoused by the House of Delegates. To this end, your Speaker has faithfully attended the regular and the special called meetings of the MAG Council and the Executive Committee of Council since the last Annual Session and has constantly strived to discharge the above responsibilities.

While the leadership of the Association and the staff have never to my knowledge consciously acted in direct opposition to the declared will of the House, nevertheless, it must be said that on occasion less than maximum effort has been made in carrying out some of the directives previously declared by the House. In approv-

ing the report of Reference Committee B, the 1975 House directed that . . . "every effort should be made by the MAG in cooperation with the AMA to seek amendments to the PSRO law to remove its most onerous provisions. This campaign should be directed by the Council itself or through an appropriate committee." Your Speaker repeatedly pointed out this directive as a reminder but no real concerted campaign for amending the statute was ever made. On September 26, 1975, the AMA and state associations were given opportunity to testify before the Federal House Ways and Means Subcommittee on this matter. Your Speaker was privileged to give formal testimony before that body in support of the 19 amendments sought by the AMA. The MAG was the only state to give such testimony in addition to that given by the AMA. It was gratifying to see the amendments passed and signed by the President on December 31, 1975.

A special meeting of the MAG Council was called by petition on November 9, 1975 to answer the question of alleged conflicting actions taken by the House at its 1974 and 1975 Annual Sessions. It was cited that while the House in 1974 declared provisions of the PSRO law to be unethical, its subsequent action in 1975, viz., to endorse MAG's applying for PSRO designation 15 days prior to the deadline, did, in fact, constitute a paradox and was, in the opinion of some, itself an unethical act. MAG Council deliberated the allegations at length. Legal counsel advised that the House was autonomous and when any action it might take conflicted with a previous action, the more recent action supervened. Various motions, both pro and con regarding the House action failed to pass and Council adjourned without taking definite action to resolve the question.

With credit largely due to staff (Messrs. Moffett and Williams), plans to change the format of the Annual Session have been developed, studied and approved by Council. These are designed with the objective of streamlining the proceedings and more efficiently conducting the necessary business of the House and of the Association. It is hoped that the more important issues can be properly considered and appropriately acted upon before the final hours of the last day, and that certification and seating of delegates and the process of election of officers can all be expedited by these changes. We believe that these concepts will be reflected in a Session just as productive as in the past but with a considerable time savings and with no restraint on reasonable debate. Suggestions and constructive criticism from any member of MAG will be thoughtfully received by the Speaker at any time.

It continues to be a coveted privilege to serve as Speaker of the House of Delegates. As I personally become more intimately involved with the affairs of MAG, I feel a deepening desire to beg every delegate to return to his own community actively seeking to involve all the physicians of Georgia to become involved, to debate, to learn, compromise and decide, then to unite our considerable strength in neutralizing the increasing number of forces seeking to completely control us and to degrade our image in the minds of the patients we serve.

FIRST DISTRICT COUNCILOR

Albert M. Deal, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Ogeechee River Robert B. Stambuk Statesboro	22	21	26	24
Burke Walter R. Voyles Waynesboro	5	5	5	5
Emanuel Carter L. Meadows Swainsboro	6	6	5	5
Laurens Grady E. Longino Dublin	29	24	31	25
Screven Gerald B. Hogsette Sylvania	5	4	4	4
Southeast Georgia Bob De Jarnette Vidalia	11	10	10	9
St. John's Parish Frank T. Robbins Hinesville	(new society)		6	6
	78	70	87	78

SECOND DISTRICT COUNCILOR

J. Dan Bateman, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Colquitt Leonard P. LaConte Moultrie	16	14	19	16
Decatur-Seminole M. A. Ehrlich Bainbridge	14	7	13	8
Dougherty George M. Chastain Albany	81	63	84	73
Mitchell A. A. McNeill, Jr. Camilla	5	5	3	3
Southwest Georgia David Wetherby Ft. Gaines	10	6	11	7
Thomas Area James L. Story, Jr. Thomasville	53	44	51	40
Tift Gerald L. Sapp Tifton	22	13	23	17
Worth R. T. Morgan Sylvester	4	3	5	4
	205	155	209	168

THIRD DISTRICT COUNCILOR

John H. Robinson, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Flint				
C. C. Greer, III				
Cordele	15	12	15	13
Peach Belt				
Perry D. Melvin				
Warner Robins	41	38	43	38
Randolph-Stewart-Terrell				
John G. Bates				
Cuthbert	8	8	8	7
Sumter				
William R. Anderson				
Americus	20	17	25	20
	84	75	91	78

SIXTH DISTRICT COUNCILOR

James M. Skinner, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Clayton-Fayette				
Charles Hendry				
Riverdale	25	23	44	35
Coweta				
Thomas Sosby				
Newman	24	20	24	19
Meriwether-Harris-Talbot				
W. G. Chambless				
Hamilton	14	13	12	10
Spalding				
Charles C. Releford				
Griffin	38	35	43	38
Troup				
Owen K. Tidwell				
LaGrange	36	30	40	33
Upson				
Pratoom Potitong				
Thomaston	19	16	24	19
	156	137	187	154

SEVENTH DISTRICT COUNCILOR

Don W. Schmidt, M.D.

It has been a great pleasure for me to serve as councilor to represent the 7th District. I am very pleased that the component medical societies of our district have shown increased interest in all matters pertaining to the problems of organized medicine.

The 7th District had two excellent district meetings which combined meaningful scientific presentations with good attendance. The membership of the 7th District now consists of 237 physicians, and it appears that the growth will continue to increase. We in the 7th District are very proud of our two medical centers in Dalton and Rome.

Each component medical society has been meeting regularly and through them I have received valuable expressions of opinion which have been very helpful to me in serving as a councilor. I feel very confident that with the interest and enthusiasm that has been prevalent in our district that organized medicine will continue to be strong and face all our challenges of the future.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Bartow				
Virginia D. Hamilton				
Cartersville	8	6	11	9
Carroll-Douglas-Haralson				
Jack Crews				
Carrollton	35	32	32	29
Floyd-Polk-Chattooga				
Jack R. Edgens				
Rome	100	80	100	75
Gordon				
William E. Dalton				
Calhoun	9	9	9	9
Walker-Catoosa-Dade				
John W. Adams, Jr.				
Ft. Oglethorpe	39	23	35	20
Whitfield-Murray				
William McDaniel, Jr.				
Dalton	55	48	63	56
	246	198	250	198

EIGHTH DISTRICT COUNCILOR

Robert E. Perry, Jr., M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Altamaha C. B. Kanavage Baxley	6	6	6	5
Ben Hill-Irwin C. Morgan Smith, Jr. Fitzgerald	7	7	7	6
Coffee Tom Parker Douglas	13	11	16	14
Camden-Charlton Eduardo Oliveira St. Mary's	6	3	5	3
Glynn Ralph H. Chaney Brunswick	57	50	63	52
Ocmulgee Richard L. Smith Cochran	15	13	17	13
South Georgia Charles Hobby Valdosta	66	56	71	52
Telfair D. B. McRae McRae	5	5	4	4
Ware L. Davis Jacobs Waycross	39	36	42	37
Wayne Ollie O. McGahee, Jr. Jesup	9	6	8	5
	223	193	239	191

NINTH DISTRICT COUNCILOR

Harvey M. Newman, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Barrow J. C. Souther Winder	9	8	8	7
Blue Ridge E. J. Fernandez Ellijay	3	3	4	3
Chattahoochee Rupert Bramblett Cumming	28	24	27	24
Cherokee-Pickens F. E. Gonzalez Canton	22	18	20	14
Elbert Harold Campbell Elberton	8	4	8	4
Franklin-Hart L. G. Cacchioli Hartwell	7	7	7	6
Habersham Lamar H. Waters Clarkesville	9	7	11	8
Hall James M. Alday Gainesville	80	66	81	71
Jackson-Banks S. A. Vickery Commerce	9	8	7	5
Stephens-Rabun Fred M. Lee Toccoa	22	21	23	23
	197	166	196	165

TENTH DISTRICT COUNCILOR

Edwin W. Allen, Jr., M.D.

Meetings were held in Augusta and in Louisville during 1975. Interesting scientific presentations were made, and social hours and excellent meals were enjoyed by the good members present.

The Jefferson County Medical Society was reorganized. All component societies in the Tenth District fulfilled the criteria as required by the Constitution and Bylaws of the Medical Association of Georgia.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Baldwin Perry Moore Milledgeville	51	30	52	28
Crawford W. Long Charles Thomas Athens	86	73	77	63
Jefferson James W. Pilcher, Jr. Louisville	8	7	9	6
McDuffie A. G. LeRoy, Sr. Thomson	6	6	7	7
Newton-Rockdale W. A. Futch Conyers	10	10	11	6
Oconee Valley Leo Wade Union Point	10	10	10	9
Walton R. M. Tankesley Monroe	7	5	7	5
Washington John W. Traer Sandersville	8	2	7	2
Wilkes Sophia Bamford Washington	4	4	5	5
	190	147	185	131

BIBB COUNTY MEDICAL SOCIETY COUNCILOR

Milton I. Johnson, M.D.

In accordance with the letter of January 19, 1976, from Dr. L. C. Buchanan, Speaker of the House of Delegates, the following is submitted as the report of the Bibb County Councilor:

The Bibb County Councilor is pleased to report that the state of medicine in Bibb County at this time is healthy and vigorous with almost all our physicians now participating in government medical programs. We now have 230 members of the Bibb County Medical Society including 19 new members obtained during the year 1975. There are 3 eligible new physicians in Bibb County whose applications for membership are being processed at this time.

In accordance with Chapter V, Section 8, of the Medical Association of Georgia Bylaws, I report that Drs. T. M. Hall, A. L. Lawrence and E. R. Stamps have elected to discontinue membership in our society.

We look forward to the new year with the hope that we shall be strong enough to meet the ever increasing challenges that quality medical care will face.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Bibb James B. Lindsay Macon	194	161	218	168

COBB COUNTY MEDICAL SOCIETY COUNCILOR

Charles R. Underwood, M.D.

The past year in Cobb County was one filled with wide ranging and substantive change hopefully destined to serve as a bench mark in years ahead. The Society offices moved into newly renovated and furnished office space. This accompanied by complete reorganization of office personnel and procedures has been designed to anticipate and satisfy future goals of the Society as we continue to increase our membership and prove even more useful to this membership. These changes were accompanied by restructuring of membership dues and a reappraisal of Society functions. In an effort to bring the Society geographically closer to the membership, Executive Committee meetings were held at all hospitals throughout the county while general membership meetings were kept as centrally located as facilities permitted within the area. We seem to have imperceptively moved, as though overnight, from a Society revolving around one major hospital only a few years back to one dealing with a number of aggressive and equally effective hospital units spread throughout the county. The realization of this fact has led our new President, Robert P. Coggins, M.D., to design committee structure and function as well as membership meetings around these geographically disparate hospital units which themselves function as a point of reference for the majority of our membership. The coming year will, then, see our meetings of all types as well as our service functions spread as equally as possible throughout the county and revolving around the several hospital units. It is this change in geographical orientation which we see as the key factor in reorienting the entire future performance of the Society leading we feel certainly, to increased membership participation and benefit from the Society.

Our hospital units continue to grow in size and improve in service capability. The year 1975 saw Cobb General Hospital complete a $12 million expansion program effectively adding 150 additional patient beds while also adding nuclear medicine and special procedure capability to the X-ray Department as well as other additional services throughout the hospital. This hospital now has a medical-dental staff of 182 members. Urban Medical Hospital also opened a new unit and reached its licensed bed capacity of 108 beds. In addition the Urban Medical Doctors Building was completed and fully occupied. The Emergency Room at Urban became well established during the year and is now an integral part of the Emergency Care facilities in Cobb County. Plans are now actively underway for enlargement of the entire facility including both bed capacity, office space and service facilities. The Smyrna Hospital now is in full operation with 100 beds available as well as a fully staffed 24 hour emergency room which opened during the past year. The Center for Interpersonal Studies continues to provide a major psychiatric facility for the area having recently completed a major office space facility. Kennestone Hospital, now along with Cobb General Hospital, administered by a joint City-County Hospital Authority, moved from the old facility opened in 1950 to an entirely new six story building adjoining the old hospital building and providing 404 beds. Expansion of all service areas was accomplished with this major alteration in the physical plan.

The Woman's Auxiliary continues active in many areas including the operation of a Gift Shop at Kennestone Hospital which contributes significantly in a financial way to a number of areas. The Society also remains active in support of the Cobb County Symposium, sponsors a free annual physical examination clinic to all athletes in the county high schools, publishes a periodical newsletter for the membership, aggressively pursues liaison activities with the Atlanta Regional Commission and with our legislators. The health insurance plan available to the membership through the Society and Blue Cross/Blue Shield was carefully and realistically revised during 1975.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Cobb Evans J. Nichols Marietta	201	182	204	169

DeKALB COUNTY MEDICAL SOCIETY COUNCILOR

Luther M. Vinton, Jr., M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
DeKalb				
Charles W. McDowell, Jr.				
Decatur	251	214	247	206

FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY COUNCILOR

John I. Dickinson, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Floyd-Polk-Chattooga				
Jack R. Edgens				
Rome	100	80	100	75

MEDICAL ASSOCIATION OF ATLANTA COUNCILOR

John T. Godwin, M.D.

The Councilors have attended all meetings and all meetings including special meetings of Council held during the time of this report.

Councilors have actively participated in all deliberations. There are no specific recommendations to be made at this time.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
MAA				
R. Carter Davis, Jr.				
Atlanta	1093	953	1102	934
John T. Godwin, Atlanta, Councilor				
T. J. Anderson, Jr., Atlanta, Councilor				
J. Harold Harrison, Atlanta, Councilor				

GEORGIA MEDICAL SOCIETY COUNCILOR

L. R. Lanier, Jr., M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Georgia Medical Society				
J. Robert Logan				
Savannah	209	193	223	202

MUSCOGEE COUNTY MEDICAL SOCIETY COUNCILOR

Jack A. Raines, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Muscogee				
Bob R. Maughon				
Columbus	162	130	176	135

RICHMOND COUNTY MEDICAL SOCIETY COUNCILOR

Ronald F. Galloway, M.D.

This represents my annual report to the House of Delegates as Councilor to the Medical Association of Georgia from the Richmond County Medical Society. The Richmond County Medical Society has had an active year under the leadership of Dr. John M. Martin as President. Attendance at meetings has been excellent. Meeting reservations have averaged 141 with as many as 225 reservations at one meeting during the year. Programs arranged by our President-Elect, Dr. Thomas L. Douglass, have been outstanding. Our January meeting was held jointly with the Augusta Dental Society, Mr. John Voigt of the Georgia Medical Care Foundation spoke at the February meeting. In March, we were entertained by the Puppet Show "Drugs Are a Drag" given by members of the Auxiliary to the Richmond County Medical Society. The April meeting was utilized to review the previous Annual Session of the House of Delegates. Dr. J. W. "Red" Chambers of LaGrange, Georgia, spoke on "What Does Organized Medicine Mean to You?" at the May meeting. Dr. Fleming Jolley, Medical Association of Georgia President-Elect, was the guest speaker at the September meeting. Mr. Glenn Frick, a member of the Governor's Commission on Medical Malpractice spoke to the Society at the October meeting. Officers were elected at the November meeting. The December meeting, the best attended of all was utilized to install new officers for the year 1976 and to present a special program of song and dance numbers performed by children of the members.

The Richmond County Medical Society has enjoyed a successful year in 1975, with increased membership and increased interest in both local and state medical matters.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1974 MAG	Members December 31, 1974 AMA Dues Paying	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying
Richmond				
Jimpsey B. Johnson				
Augusta	305	283	327	282

COMMITTEE ON ALLIED HEALTH

J. Rhodes Haverty, M.D.

The new Committee on Allied Health has not yet held its first meeting. The committee will meet when a sufficient number of issues are generated. It is anticipated that the committee will become active in legislative matters concerning allied health, in the new Georgia Society for Allied Health Professions, and will act as liaison between the MAG and the state chapters of various national allied health professional organizations.

COMMITTEE ON EDUCATION

Nicholas E. Davies, M.D.

The Education Committee has been very active during the past year, and only a brief summary of its activities will be included in this report. The report will be divided into sections titled Physician Education, Public Education, Medical Schools, and Miscellaneous.

PHYSICIAN EDUCATION

The Medical Association of Georgia has assumed the responsibility of helping all physicians in Georgia continue their medical educations. The Education Committee believes that MAG should be an education broker or promoter and not a direct provider of education programs, with the exception of its annual Scientific Assembly. The Committee has proceeded under this basic premise.

(a) **Accreditation Subcommittee**—This subcommittee, chaired by James Maughon, M.D., has administered the procedure by which the following institutions were accredited for CME during the past 12 months: American Cancer Society, Georgia Division; Georgia Radiological Society; DeKalb General Hospital, Decatur; Memorial Medical Center, Savannah; Georgia Psychiatric Association; Martin Army Hospital, Ft. Benning; Georgia Baptist Hospital, Atlanta.

By being accredited, the educational programs of these institutions may carry Category I credit toward the Physician's Recognition Award of the American Medical Association. Because a number of medical organizations and a number of states are requiring physicians to meet the educational criteria for this award, accreditation has assumed increasing significance during the past several years.

(b) **Continuing Medical Education Subcommittee**—This subcommittee, chaired by LaMar McGinnis, M.D., is concerned with helping new hospital education programs get started and with upgrading existing programs. Although the MAG has accredited fourteen institutions in Georgia, over 30 others have inquired about the accreditation procedure. The subcommittee is helping these programs in their development. This will be the major thrust of the Education Committee in 1976 and will consume a majority of the time of our Education Director.

The subcommittee is charged with the responsibility to keep abreast of developments in other states regarding mandatory continuing education for membership in state medical societies and for relicensure. This topic was discussed at length at the March meeting of the Education Committee, and a recommendation was forwarded to the House of Delegates (see Supplemental Report of the Education Committee, C 13A).

(c) The Scientific Assembly was promoted and assisted by the Education Committee. We felt that the Session was a success, especially when it is realized that this is the first attempt under the present format. We anticipate continued growth of the Scientific Assembly and the production of a quality program in the years ahead.

(d) The Education Committee has tried to stress its concern for individual physicians who seek to continue their educations. Toward this end, our Education Director, Stephen Daniel, Ph.D., has accumulated considerable material on education programs in Georgia and surrounding states. Some of this information has been published in the *Journal of the Medical Association of Georgia*. Dr. Daniel organized an exhibit at the Atlanta Graduate Medical Assembly on continuing medical education opportunities.

(e) **Medical Audit for Education**—Dr. Austin Flint chairs this new subcommittee, which is concerned with studying the educational potential of medical audit and peer review. It is staffed by Mrs. Sybil Wells, who has had considerable experience with audit, as has Dr. Flint. We are hoping they can be leaders in this very active field.

HEALTH EDUCATION OF THE PUBLIC

The Education Committee believes with many experts that the surest and best way to improve the overall health of the nation is to educate the general public regarding basic health issues, including nutrition, exercise, dental hygiene, smoking, alcohol and drugs, and family planning. The committee feels that these issues are too important to leave to educators alone. If physicians are indeed the leaders of the health care team, then physicians should be the leaders in health education. This is a new role for most physicians, and the Education Committee is moving slowly. Again, we believe the MAG should act as consultant and counselor and not be a direct provider of health education in most instances.

(a) **Health Education in Schools**—Dr. John Harrel has taken the initiative in working with the state PTA and with the state Department of Education in the area of health education curricula in the schools. Contact has been made with the Atlanta school system and others interested in health education. Anne Somers, D.Sc., the principal speaker at the plenary session of the Scientific Assembly, spoke on this topic and gave us many ideas about how we should proceed with this and other public education programs.

(b) **Patient Education**—This field is becoming more important each month, with several new patient education projects being instituted. We see our role as coordinators of the various voluntary health agencies, health departments, and the various medical and specialty societies. Our goal is a large one—to make every physician's office a health education center. We believe that if we can get all concerned to work together, this is a distinct possibility.

(c) **Media**—Dr. Carter Smith, Jr., is leading the committee's efforts in health education through the various news media in the state. Radio and television have been interested in various ideas, but as yet nothing concrete has been done.

MEDICAL SCHOOLS

The relations between the Education Committee and the medical schools of the state have been exemplary. The schools have been well represented on the committee, and the committee, in turn, has assisted the schools in their continuing education programs. We hope to do more in the years ahead as more community hospitals develop education programs requiring educational assistance from the medical schools.

The Biennial Conference on Medical Education sponsored by the Medical Association of Georgia and the medical schools in Georgia was held on March 5-7, 1976. It was directed by Dr. Nat Smith, Dean of Mercer's Medical School, and was attended by representatives of Emory, the Medical College of Georgia, Mercer, Morehouse, and the Medical Association of Georgia. The meeting was too late to have the results published in this report, but its impact will be felt during the next two years.

MISCELLANEOUS

Numerous probes into various areas have been made by members of the committee, but this heading will include only those topics that have a good chance for success during the next several years.

(a) **Small Hospital Library Information Center Project**—This is a new concept that is based on several factors: (1) the existing rapid communication network among medical libraries; (2) the availability of rapid duplicating methods; and (3) the general opinion among the public, strengthened by several recent lawsuits, that medical care should be as good in one part of the country as it is in another part under equal circumstances.

There now appears to be some funds available to small hospitals to help them establish core libraries (medical, nursing, paramedical), staffed by a non-librarian and tied in with a larger library nearby. This project holds great promise for the community hospitals about the state that have no educational resource facilities.

(b) **Emory University—MAG Institute on Medicine and Humanities**—Through the initiative of MAG's Director of Education, MAG and Emory's Community Education Program have been awarded a grant to sponsor a one-day institute on Decision-Making in Health Care. Participants will discuss scientific, institutional, legal, ethical, and financial aspects of medical decision-making.

CONCLUSIONS

There is a great deal of activity in continuing medical education and in other education projects affecting physicians around the country. The Education Committee is involved in many of these and has been successful with many of them. But the primary thrust of our program must remain that of helping our members and other physicians in the state continue their medical education. Towards this end, our greatest asset has been having Stephen Daniel, Ph.D., working for us for the past 18 months. Dr. Daniel was hired with funds from the Georgia Regional Medical Program and would be maintained with MAG funds once the federal funds have expired. During the next 12 months Dr. Daniel will travel to all parts of the state helping hospitals develop their education programs. He will be actively supported by all 38 members of the Education Committee.

There are a number of jobs that need to be done. We will welcome volunteers who would like to join with us in our educational projects.

COMMITTEE ON EMERGENCY MEDICAL SERVICES

Carl Jelenko, III, M.D.

The MAG EMS Committee met on May 31, 1975, September 6, 1975, and February 21, 1976. Chief activities of the Committee comprised development of proposed regulations for Emergency Medical Technicians. These regulations were developed for the advanced Emergency Medical Technician/Ambulance in conjunction with the combined Board of Medical Examiners. The final regulations were submitted to the Georgia General Assembly, passed the Senate, but did not get to the House floor due to the lateness of introduction.

A continuing education course was developed directed at the nonemergency room physician. This will comprise the second continuing education course offered by the Committee and will occur in June, 1976, in Savannah, Georgia.

The Emergency Medical Services Systems at Hartsfield International Airport underwent considerable discussion and study. By February, 1976, a methodology had been developed and was in use at the airport. Problems continue to exist with regards to accessing the first aid area and airport-wide publicizing of an emergency medical phone number for the airport complex. An advanced life support team comprised of EMT/As employed by the Atlanta Fire Department is on duty at all times.

The Committee moved to develop an issue of the *JMAG* to discuss availability, functions, and capabilities of EMTs. It was planned to develop a tear-out brochure as an insert to that *Journal* for continued use by the physician. In addition, the Georgia Chapter of ACEP will be encouraged to hold a demonstration of EMT functions at the November, 1976 MAG Scientific Assembly.

COMMITTEE ON OCCUPATIONAL HEALTH

Tom Howell, M.D.

Annual meeting of the Occupational Health Committee is to be held in late February so that the changes in workmen's compensation laws may be discussed by Judge Al Crenshaw.

Members of the Committee have participated in our state rehabilitation effort. The Committee was responsible for the medical program for the "college" of the International Association of Industrial Accident Boards and Commissions. The Chairman of the Committee gave a presentation to the Georgia Business and Industry Association Seminar regarding the value of occupational health exams. Members of the committee have met regularly with the medical legal council of the Workmen's Compensation Board in an effort to assist in preparing this year's workmen's compensation legislation. The Chairman of the Occupational Health Com-

mittee has been appointed Vice Chairman of Advisory Committee to the I.A.I.A.B.C. The committee assisted in presentation of medical topics at the Seminar for Industrial Hygiene held at the Center for Disease Control.

By way of information, the Medical Association should be advised that the Workmen's Compensation Board is considering a return to a system of "fee schedules" rather than "usual and customary." This has been requested because of repeated requests from industry to supervise rising costs of workmen's compensation insurance. This is not to be presented at the present Legislative Session and I am assured that the Medical Association will be given all opportunities for input at the appropriate time.

COMMITTEE ON PHYSICIAN-LAWYER LIAISON

T. A. Sappington, M.D.

This committee met once during the past year on the 15th of November, 1975. Several problems and complaints were discussed.

A subcommittee to revise the booklet entitled "Principles Governing Physician-Attorney Relations" has been appointed and revision of the booklet should be completed in the near future.

It is felt that this committee could and should be more active in the future.

No request is made at this time for budgeting any funds for this committee.

INTERSPECIALTY COUNCIL

James K. Van Buren, M.D.

MAG's Interspecialty Council is composed of the representatives of 22 medical specialty societies in the state. The latest addition to the Council is the specialty of emergency medicine, which was accepted for representation in January, 1976.

The Council held three meetings during the 1975-76 year and concerned itself principally with the following items:

1) Interspecialty Council Guidelines: Long in need of document which would specify its structure and function, the Council grew up guidelines which were approved by MAG's Executive Committee in August, 1975. The guidelines define the composition of the Council, set criteria for the representation of additional specialties, outline the duties of officers and representatives, and set forth the charges of the Council. The Council's general function is liaison between its member specialty groups and the MAG. Specific areas of liaison are legislation, continuing education, criteria development for evaluation of medical care, and the planning of the annual MAG Scientific Assembly.

2) Defining physicians' specialties: At the request of the state Medicaid Office and the MAG's Executive Committee, the Council has formulated definitions of the various medical specialties represented on the Council. The intended purpose of the definitions is to aid the Medicaid Office in determining fee schedules for the reimbursement of services rendered by physicians under the Medicaid program.

3) MAG Annual Scientific Assembly: The Council continues to work closely with the Committee on Scientific Assembly in planning and coordinating specialty society participation in the annual Assembly. The 1976 Scientific Assembly will be held November 19-20 at the Omni International Hotel in Atlanta.

AD HOC COMMITTEE ON TRANSFUSIONS AND TRANSPLANTATIONS

Frank Matthews, M.D.

This Ad Hoc Committee was established by Executive Committee of Council on May 9, 1974, and was charged to consider implementation of the federal government's national blood policy in Georgia.

Subsequent review of proposed rules and regulations suggested that Georgia is already, for the most part, covered by programs which can accomplish all the goals of the National Blood Policy with only a minimum of change. It seemed reasonable to try to use these existing programs, which have long been used by the Red Cross and the hospitals and physicians of this state, instead of trying to establish new and competing programs.

Accordingly, on March 9, 1975, I carried the report of the committee to the Executive Committee of Council, which concurred with the recommendations:

1. That MAG, the Red Cross regional offices (Atlanta and Savannah), the CSRA blood assurance program (Augusta), and any other interested parties, in concert, petition the American Blood Commission for recognition as integrated regional programs and
2. That the Ad Hoc Committee be continued as liaison with the Red Cross until the details for recognition are accomplished.

The American Blood Commission, charged with the implementation of this program, has moved rather slowly. As of January 13, 1976, correspondence from Mr. Mark Knowles, Executive Director, advises that final criteria for performance of regional associations of blood banks will probably be adopted April 1 to 3, 1976. When these criteria are received, the committee will resume its goal of trying to implement federal requirements with the least possible disruption of good existing practices.

ANNUAL REPORT OF COMMITTEE ON PRISON HEALTH CARE

J. Rhodes Haverty, M.D.

MAG's Committee on Prison Health Care was created in November, 1975, in response to: 1) a request by Georgia's Department of Corrections to MAG for advice and assistance in improving the health care delivered to inmates of the state's prisons, and 2) the potential for MAG to be selected to work with the American Medical Association in a pilot program to improve the medical care and health services in municipal and county jails through the development of a national certification program to be conducted by state medical associations.

The committee is charged with studying and recommending ways to improve the delivery and promote the availability of health care in non-federal prisons in Georgia. The committee is responsible for liaison with appropriate agencies and institutions, and with other committees interested in health care in the prison sys-

tem. Executive Committee expressed its commitment to working to improve health care in jails whether or not project funding could be secured from other sources.

MAG was subsequently (in January) awarded $25,000 through the AMA and the Law Enforcement Assistance Administration to conduct a pilot program in a limited number of Georgia jails. DeKalb County Jail, Atlanta City Jail, Atlanta Prison Farm, and the LaGrange Jail were selected as pilot sites for the Georgia project. The pilot program will involve: 1) a survey of the health care services in representative institutions in Georgia, 2) the development of recommendations for modifications to these services, 3) and measurement of the impact of these modifications. MAG's results will be input to the AMA's development of the national certification program. It is anticipated that the pilot project will continue for up to three years as the national program is being developed. The committee feels extremely fortunate that MAG was selected to participate in this AMA effort—an effort to which the medical community can make a significant and lasting contribution.

The committee has met and will meet again in February, and has begun to consider the issues raised by the Georgia Department of Corrections as well as by the AMA grant activity. The committee expects to be an active one, and earnestly desires the participation of interested Georgia physicians in its activities.

COMMITTEE ON THE MEDICAL ASPECTS OF SPORTS

Fred L. Allman, Jr., M.D.

Purpose of Committee: The purpose of the Committee on the Medical Aspects of Sports of the Medical Association of Georgia is to help make member physicians more knowledgeable concerning the health needs of the athlete. These needs include information concerning prevention, recognition, treatment, and rehabilitation of injuries and illnesses that are associated with both organized and recreational sports participation. The committee also serves as liaison to help promote a close mutually beneficial relationship between the medical profession and coaches, school administrators, athletes, and parents.

Projects of the Committee: As in past years, this committee sponsored a program in conjunction with the Georgia High School Coaches Association clinic and three outstanding speakers spoke to the coaches group. Also, as in past years Mrs. Mary Helen Goodloe was responsible for the nutrition luncheon which is funded each year by Coca-Cola. This has become a very important part of the one-day meeting. This year the meeting will be held on August 5 and will be for coaches and physicians.

Certification of Coaches: The committee continues to encourage school administrators and the Georgia High School Coaches Association to implement the certification of coaches as has been done in several other states. The committee feels that this is a very necessary action to be taken as soon as feasibly possible.

News Release for Heat Precautions: Each August the committee sends to the various news media throughout the state precautions which should be taken during hot weather practice sessions. It is felt that the knowledge which has been disseminated has been helpful in keeping Georgia from having any serious heat illnesses in recent years.

Improved Form for Pre-Participation Evaluation: Further attempts have been made to upgrade the pre-participation physical evaluation of athletes for participation in sports throughout the state and it is hoped that through the efforts of the committee a more meaningful and worthwhile form will be adopted by an increased number of schools.

New Projects of the Committee: The committee is attempting to encourage athletic teams throughout the state, especially football, to have a physician designated as team physician who will aid them in the overall medical program for their athletic teams. It is hoped that the committee can aid teams who are unable to obtain a physician on their own to be put in contact with the appropriate individuals within each medical society so that adequate medical care will be available.

Development of Modified Program: With improved evaluation of participants for high school athletics it is hoped that the example that has been established in New York State with a modified program based upon the capabilities and maturation of the individual can be implemented within our state as soon as possible. It is felt that such a program is very helpful in reducing the number of serious injuries.

Improved Rehabilitation: It is hoped that through dissemination of appropriate conditioning rehabilitation publications that a better job of rehabilitating athletes following injury can be implemented.

Sectional Meetings: The committee will encourage physicians throughout the state to sponsor local meetings on the medical aspects of sports and will assist the local members whenever possible in providing material and speakers upon their request.

In conclusion, the committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationship of health, education, and sports participation. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal natural relationship that deserves the attention of every physician in Georgia.

GEORGIA REGIONAL MEDICAL PROGRAM

Luther M. Vinton, M.D., Grantee Liaison Officer and J. Gordon Barrow, M.D., Coordinator

On April 30, 1976, the Georgia Regional Medical Program will complete its ninth year of operation. The Medical Association of Georgia has served as Fiscal Agent for the program since its inception. Final termination of the program will be accomplished prior to the end of October, 1976. By that time, the Medical Association of Georgia will have received indirect cost payments in excess of $623,000 for the use of the space in its building and grants totaling more than $18 million will have been made to Georgia institutions and health related agencies. Grants directly to the Medical Association of Georgia have totaled $284,563.57 during this period, and the county societies and foundations affiliated with the Medical Association of Georgia have received grants totaling $175,775.13.

We believe that the leadership provided by the medical community in the activities of the Regional Medical Program have resulted in one of the outstanding

programs of health services development in the country. It is with great regret that we bring this program to a close.

RESEARCH AND DEVELOPMENT DIVISION

Earnest C. Atkins, M.D., Principal Investigator

The Research and Development Division of the Medical Association of Georgia has undertaken a number of health services research and development activities since June, 1971, ranging from the quality assurance efforts under the direction of MAG's EMCRO Committee to the Georgia Cancer Registry activity under the direction of MAG's Cancer Committee. Each of these activities is described below in terms of its purpose and benefits.

EXPERIMENTAL MEDICAL CARE REVIEW ORGANIZATION

This activity began in June of 1971 and concluded in November of 1974. Funding totaling $645,245 was received from the National Center for Health Services Research and Development for experimentation in the development of quality of care evaluation methodology. Approaches to the evaluation of hospital in-patient care and of nursing home care were developed utilizing computer generated reporting. During this project period, considerable development in the state of the art of medical care evaluation occurred, and our eventual criteria model was that of outcome evaluation with a clearly present process component. Working through MAG's Interspecialty Council, project staff was able to assist 12 Georgia specialty societies in the development of criteria which were distributed to the medical staffs of Georgia hospitals as an aid to their development of medical care evaluation programs. Without EMCRO project staff, MAG would have had no capability to assist the specialty societies in addressing the issue of medical care evaluation. Furthermore, the EMCRO project of MAG made a number of unique contributions at the national level including the first sophisticated model for the evaluation of nursing home care. Elements of the hospital discharge abstract system (including programs) are in use by various hospitals within Georgia at this time, though a single statewide hospital data system is not now operational.

QUALITY CARE ASSURANCE

Between 1972 and 1974, funding in the amount of $60,000 was received from the Georgia Regional Medical Program for the purpose of assisting Georgia's specialty societies in the continuing process of criteria modification and updating. The specialty societies—through panels consisting largely of chairmen and members of hospitals medical audit committees—emphasized the use of criteria to meet the emerging medical audit requirements of the Joint Commission on Accreditation of Hospitals. The most recent revisions of these criteria will be made available to medical staffs in June, 1976.

SMALL HOSPITAL PROJECT

During 1975 and into the summer of 1976, the Georgia Regional Medical Program has provided $223,887 to MAG's Research and Development Division for the purpose of assisting hospitals in implementing quality assurance programs. Workshops for physicians and for medical audit committee assistants are being held throughout the state. These local workshops utilize project staff and Georgia physicians active in Joint Commission audit. The workshops have been—and continue to be—very well-received by those in attendance. Comparable educational programs are not available to Georgia hospitals from other sources. It is anticipated that funding will also be made available to continue this activity into 1977, as this project is one of high priority to the Georgia Regional Medical Program.

HEALTH DATA SYSTEM

Between June 1973, and summer, 1976, MAG's Research and Development Division will have received $555,934 from the National Center for Health Statistics for the purpose of developing a model for the collection of hospital care statistics. The model being developed is a hospital discharge abstract system oriented to JCAH and other review requirements. This funding has permitted MAG to provide assistance to the Georgia Medical Care Foundation in the development and implementation of its concurrent hospital review program. Of central importance in our project's model is the need to preclude the imposition of a series of new data requirements (by state and federal health agencies) by our meeting these data needs through a single data system.

REGIONALIZATION OF CANCER SERVICES

The Georgia Regional Medical Program funded MAG's Research and Development Division in the amount of $13,915 in 1975 to design a data collection instrument and computer system to permit the collection of cancer research data in Georgia. This plan was complete and formed the basis for the award to Emory University of a SEER grant by the National Cancer Institute this year. The presence of Georgia's SEER data system makes Georgia eligible for participation in other cancer programs of the National Cancer Institute.

GEORGIA CANCER REGISTRY

MAG's Research and Development Division has operated a centralized cancer registry for Georgia hospitals since 1974. The Georgia Department of Human Resources has provided a total of $139,461 over the last two years in support of this activity. The project provides consultant services to the cancer registry personnel of the 20 participating hospitals emphasizing the accrediting requirements of the American College of Surgeons. Educational seminars and computerization of the cancer registry operation are services also provided by the Georgia Cancer Registry. It appears, at this time, that funding from the Georgia Department of Human Resources will be awarded for this next fiscal year as well.

PHYSICIAN MANPOWER QUESTIONNAIRE

The Medical Association of Georgia has provided a total of $9,400 to the Research and Development Division to collect baseline data on the pattern and distribution of physician manpower in Georgia. Analysis of this data by MAG's Committee on Access to Health Care is expected to identify needs and priorities for fu-

ture MAG activities dealing with presumed physician maldistribution. The manpower report is included in the report of the Committee on Access to Health Care.

AMA HEALTH CARE IN JAILS

The Medical Association of Georgia has been awarded $25,000 of Law Enforcement Assistance Administration funds to work with the American Medical Association in a pilot program to improve the health care in municipal and county jails through the development of a national certification program to be conducted by medical societies. The pilot program will involve: 1) a survey of the health care services in representative institutions in Georgia, 2) the development of recommendations for modification to these services, and 3) measurement of the impact of these modifications. Pilot sites in Georgia include the Atlanta City Jail, and Troup, DeKalb, Upson, and Monroe county jails.

The Administrative and financial activities of the projects described above are subject to the same audits and reviews as are all federal grants and contracts, and, in addition, a management audit by Arthur Young, Inc. was performed in 1974. No audit exceptions of any type have been identified, and no changes in administrative procedure have been directed by any of these audits or by federal project officers.

It is felt that the purpose of each of the preceding activities has been accomplished. The funding agencies have accepted the results, analyses, and reports, of these projects, and MAG has benefited from the presence of the technical and other skills of these project staff members through staff support of MAG committee activities both directly and indirectly related to the projects themselves. MAG has developed staff competence that would otherwise have been unavailable to it, competence that permits MAG to address the wide variety of issues and responsibilities that confront it.

A number of other grants and contracts have also been applied for that were not subsequently awarded to the Research and Development Division. They are described below by project title, organization to which application was submitted, date of application, amount of funding requested, and purpose of project.

Health Care Plan: Kellogg Foundation; May, 1973; $1,500,000; To survey and analyze health care need amenable to physician intervention.

Continuing Education in Cancer: National Cancer Institute; August, 1973; $294,829; To develop and evaluate the effectiveness of a coordinated program of continuing education in cancer.

Evaluation of Geriatric Care: Georgia Regional Medical Program; October, 1973; $100,000; To continue development of means of evaluating quality of geriatric care.

Nursing Home Medical Record: U.S. Public Health Service; December, 1973; $264,374; To develop and test a nursing home medical records system.

Nursing Home On-Site Data Component: National Center for Health Services Research and Development; December, 1973; $407,101; To develop a data component to assist in on-site nursing home review.

Inpatient Outcome Evaluation: Bureau of Health Services Research; January, 1974; $500,828; To determine the feasibility of integrating outcome measures into a hospital discharge abstract system.

Nursing Home Review System: Bureau of Health Services Research; February, 1974; $238,681; To evaluate nursing home review methodologies.

Physician Manpower Distribution: Georgia Regional Medical Program; June, 1974; $25,442; Analyze potential under-service and under-utilization in selected Georgia counties.

Physician Reimbursement Experiment: Social Security Administration; October, 1974; $362,594; Evaluation of Impact of CHEC Program on utilization patterns and cost.

Surveillance, Epidemiology, and End Results: National Cancer Institute; November, 1974; $1,737,260; To develop a data base and cancer epidemiology/research capability.

Community-based Cancer Control Program: National Cancer Institute; November, 1974; $99,830; To develop a comprehensive community-based cancer control plan.

Criteria Development (Continuation): Georgia Regional Medical Program; November, 1974; $8,451; To continue to assist specialty societies in their criteria development activities.

Short-term Technical Data Studies (End Stage Renal Disease and Other Programs: Bureau of Quality Assurance; December, 1974; $33,579; To conduct data studies as needed.

Critical Health Manpower Shortage Areas: Region IV, HEW; January, 1975; $47,181; To assess health manpower needs in selected rural Georgia counties.

Health Manpower for Rural Georgia: Social and Rehabilitative Service; May, 1975; $215,893; To assess health manpower needs in selected rural Georgia counties.

THE *JOURNAL*

Edgar Woody, Jr., M.D., Editor

CONTENT

During the 1975-1976 year we have continued our efforts to plan theme issues involving several articles and the cover devoted to a general subject. In April we explored the new specialty, Emergency Medicine; May highlighted High Blood Pressure Month; June, traditionally, involved printing of Annual Session proceedings; October was devoted to continuing medical education and included the program for the November Scientific Assembly; January we explored the revised Medical Practice Act; February was the Annual Session program issue; and March was devoted to several articles on "the disabled doctor" and what can be done for him. An insert in the July issue provided members with a convenient form on which to record their continuing medical education activities for the AMA's Physicians Recognition Award.

CREDITS

Appreciation is expressed for the members who contributed articles published over the previous year, and to those providing our special pages—Shirley Preston of the American Cancer Society, Georgia Chapter; I. W. Joines, II, M.D. and the Georgia Heart Association; J. Winston Huff, MAG legal counsel; and J. G. McDaniel, M.D. for editing the feature page, "I've told this before. . . ." He has been joined by several additional authors in the past year for this set of stories. Bob Hamill is to be thanked for his excellent covers.

In addition, we thank staff members at the headquarters office for their attendance at and contribution to monthly contents meetings.

COSTS

Printing costs have risen only slightly in the past year and have involved paper, alteration charges and reprints.

Successful efforts were made to reduce the costs of printing the 1975 Yearbook through changes in printer, size, format, binding method and paper weight. In addition, some material was deleted from the yearbook, including the Constitution and Bylaws which was printed separately in a reduced quantity.

STATE MEDICAL JOURNAL
ADVERTISING BUREAU

Improvements have been seen in the national advertising picture over the previous year, with this national agency based in Chicago continuing to do an excellent job for us and the other member state medical journals. The Bureau recently reported on its selling efforts to 50 different pharmaceutical houses. Resistance on their part involves the reality that the state journals have higher costs per ad page due to low circulation as compared with national specialty and commercial journals.

The editor and managing editor joined other state journal staff members at the September Biennial Journal Conference in Chicago. Through panel discussions and workshops, considerable information of value was exchanged on advertising, printing costs and readership boosters.

COMMITTEE ON CANCER

Hoke Wammock, M.D.

During the past year, the MAG Cancer Committee continued its responsibility for activities previously initiated (including the Georgia Cancer Registry and the Georgia Cancer Management Network) and began efforts that may result in programs in additional areas (including identification of topics and materials relating to diagnosis of cancer).

The Georgia Cancer Registry continues to be operated by the Medical Association of Georgia under contract with the Georgia Department of Human Resources. While this past year's budget was inadequate to permit expansion of registry services to additional hospitals, consultant and other services were made available to the seventeen participating hospitals to assist them in meeting the accreditation requirements of the American College of Surgeons.

The Cancer Committee, representing the physicians of Georgia, was kept informed of the progress of the Georgia Cancer Management Network, and expressed its commitment to continuing to provide needed input to the activities of the Network—a vehicle, like the Cancer Committee itself, through which physicians can act on matters relating to cancer. It is felt to be essential that the Georgia Cancer Management Network continue its important work. The committee was pleased to hear that Robert L. Brown, M.D., has become the medical director of the Georgia Cancer Management Network.

The Cancer Committee devoted considerable discussion to the needs of the family practitioner with regard to diagnosing cancer. It was felt that means of providing assistance in cancer diagnosis should be identified and the feasibility of providing such assistance examined.

The Chairman wishes to extend his personal appreciation to the members of the committee for their continued interest and cooperation.

SUBCOMMITTEE ON RURAL HEALTH OF THE COMMITTEE ON THE ACCESS TO HEALTH CARE

Irving D. Hellenga, M.D.

The Chairman and staff, Assistant Executive Director Adam Jablonowski attended the 28th National AMA Conference on Rural Health on Thursday and Friday, March 20 and 21, 1975, at the Hotel Roanoke, Roanoke, Virginia. He also participated the preceding day in two workshops sponsored by the AMA Council on Rural Health for Chairmen and members of the State Medical Association's Rural Health and Medical Association Staff.

The committee sponsored the 11th Annual Rural Health Conference at the Medical Center of Central Georgia Hospital in Macon on October 27 and 28, 1975. Important to the audience, one consisting primarily of representatives of the Georgia Farm Bureau, and of the Extension Service of the University of Georgia, was the presentation of the entire resident staff in family practice of the Family Practice Center at the Medical Center of Central Georgia Hospital. Speaker Tom Murphy of Bremen presented the legislative strategy which he is using to promote rural health in Georgia. Other speakers and participants including M. J. Duttera, M.D. of LaGrange, who talked on M.D. utilization in rural area.

The Chairman also chaired a subcommittee on physician's services, for the Task Force on Health and Health Related Services for the Elderly, Program on Aging, GMPDC, held in Gainesville, Georgia, 2 December 1975.

STUDY OF STATE INSTITUTIONS

Edwin W. Allen, Jr., M.D.

The Committee on Study of State Institutions met only once during 1975. Since this time the committee chairman has had confrontations with the Governor, the Medical Advisory Sub-Committee of the Board of Human Resources, and the Board of Human Resources itself.

A physician has been named as Medical Superintendent of the Central State Hospital, and in theory, the physicians are responsible directly only to this superintendent. They are no longer supposed to be supervised by psychologists, social workers, and other paramedical personnel regarding medical matters. Although numerous complaints continue to present, it is felt that working conditions for the physicians at the Central State Hospital have improved. There have been no further reports of the practice of medicine by paramedical personnel.

New Business

The Speaker proceeded to new business calling for the introduction of resolutions. The following resolutions were then presented:

Cocaine Supply (R1-76)—Refcrence Committee B

State Health Coordinating Council (R2-76)—Reference Committee B

Reporting Handicaps of Drivers (R3-76)—Reference Committee C

Balanced Budgeting (R4-76)—Reference Committee F

Utilize Peer Review Mechanisms (R5-76)—Reference Committee B

Cost Accountability Committee (R6-76)—Reference Committee B

Crawford W. Long Museum (R7-76)—Reference Committee D

Medical Ethics (R8-76)—Reference Committee B

Osteopathic Physicians (R9-76)—Reference Committee D

Title of MAG Chief Executive (R10-76)—Reference Committee A

Drivers License Advisory Board Guidelines (R11-76)—Reference Committee C

AMA Membership Poll Regarding National Health Insurance (R12-76)—Reference Committee C

Deficit Budgeting and Spending (R13-76)—Reference Committee F

Realignment of MAG Districts (R14-76)—Constitution and Bylaws

DHR-Medicaid Controlled Medical Assistance Drug List (R15-76)—Reference Committee C

Balanced Federal Budget (R16-76)—Reference Committee C

House of Delegates Timetable (R17-76)—Reference Committee A

The Speaker then recognized Earnest C. Atkins, MAG Secretary, for the purpose of presenting a special resolution to Dr. James A. Kaufmann for dedicated and outstanding service to the Association in the field of legislation. The House adopted the resolution by unanimous consent.

The Speaker then adjourned the First Session of the House of Delegates at 12:35 p.m.



James A. Kaufmann (L) of Atlanta is recognized with a special resolution thanking him for his many years of dedicated effort on legislative activities. The resolution is presented by Earnest C. Atkins, Secretary of the Association.



Our Bicentennial Doctor Says:

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November 19-20, 1976

Make continuing medical education
a pleasurable experience at . . .

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- Full AMA accreditation applied for
- Luncheon and plenary session with a nationally-known guest speaker
- Educational Program for spouses
- Alumni Night
- Ice skating, Atlanta Flames Hockey, Hawks Basketball

YOU WILL RECEIVE A FLYER IN THE LATE SUMMER GIVING FULL DETAILS

Georgia Medical Political Action Committee Brunch

Saturday, April 10, 1976

The Third Annual GaMPAC Brunch was held in Colony Hall of the Holiday Inn at Jekyll Island at 10:30 a.m., Saturday, April 10, 1976.

J. Daniel Bateman, M.D. of Albany, Chairman of the Georgia Medical Political Action Committee, introduced special guests, and those seated at the head table: Mrs. Dan Bateman, Dr. and Mrs. Earnest C. Atkins of Decatur, James A. Kaufmann, M.D., of Atlanta, Mrs. Russell Andrews of Rome, Auxiliary Legislative Chairman, Mr. James M. Moffett, Executive Director of MAG, and Mr. Rusty Kidd, Director of Legislative Activities for the Association.

The newly appointed (and reappointed) Board of Directors for GaMPAC were presented, and are as follows: Dan Bateman, Albany, Chairman; Earnest C. Atkins, Decatur, Secretary-Treasurer; Leon Curry, Metter, First District Chairman; Robert P. Wight, Tifton, Second District; James Sullivan, Columbus, Third District; James Joiner, Decatur, Fourth District; William C. Collins, Atlanta, Fifth District; Curtis Batchelor, Bremen, Sixth District; Lee Battle, Rome, Seventh District; Jack Menendez, Macon, Eighth District; Billy Hardman, Gainesville, Ninth District; and Ken McDonald, Augusta, Tenth District.



GaMPAC speaker James A. Kaufmann (R), joined by Dr. and Mrs. Dan Bateman at the head table, stresses the need for unified effort in the Legislature.

Special recognition was given for the outstanding job done by the GaMPAC secretary, Miss Lynn Pearson, who is responsible for dues monies, membership records and numerous other duties.

Over 300 members and their wives enjoyed the champagne, Dixieland music and buffet brunch, which was followed by several speakers giving a complete history of GaMPAC. The origin of the Committee and its purpose was reviewed by James M. Moffett, followed by Earnest C. Atkins, M.D. who explained how and why GaMPAC recruited members and began to grow. James A. Kaufmann, M.D., Chairman of MAG's Committee on State Legislation, gave a brief but inspiring talk as to why every MAG member also should be a member of GaMPAC. He stressed the importance of the effort as contributions to political candidates open doors to those promoting medicine's viewpoint.

Rusty Kidd outlined what GaMPAC is today and how the Board and Executive Committee are nominated and function. He reviewed the selection process for distribution of campaign funds. Dan Bateman, GaMPAC chairman, concluded the program with an additional push for membership with the announcement of the 1975-1976 GaMPAC awards. The largest percentage increase of dollar contributions category was won by the Medical Association of Atlanta. This award was accepted by William Collins, M.D., Fifth District chairman.

Winner of the category naming the largest district percentage increase in membership was the Third District. James Sullivan, Third District Chairman, accepted the award.

The county society showing the largest percentage increase in membership was Peach Belt, and Lamar Pilcher accepted this award.

Second Session House of Delegates

Sunday, April 11, 1976

The Second Session of the House of Delegates of the Medical Association of Georgia's 1976 Annual Session Business Meeting was called to order at 9:00 a.m. on Sunday, April 11, 1976, by Speaker L. C. Buchanan, M.D., Decatur, in Colony Hall, Holiday Inn, Jekyll Island, Georgia.

The Speaker called upon the Reverend Dr. Junius J. Martin, Rector of Christ's Church, Frederica, St. Simons Island, for the invocation.

Speaker Buchanan asked for a report on attendance from Dr. Frank Miller, Chairman of the Credentials Committee, and it was reported that 157 duly elected delegates representing 45 component county medical societies were present for the Second Session.

The Speaker reminded the House that the polls would remain open until 9:30 a.m. to accommodate those delegates who were unable to vote prior to 9:00 by reason of meeting with their county society caucuses.

Reference Committee Reports

Speaker Buchanan called for reports from the Reference Committee Chairman. The Speaker briefly restated the procedure that would be followed and then proceeded to call for reports from Reference Committees in the following order:

REPORT OF REFERENCE COMMITTEE F

H. DUANE BLAIR, M.D., *Chairman*

Chairman Blair reported to the House that the reports and resolutions referred to Reference Committee F had been considered by the committee which met at 2 p.m. in Colony Hall, at the Holiday Inn, Jekyll Island, Georgia, on April 8, 1976.

Members of the Reference Committee present included H. Duane Blair, M.D., Decatur, Chairman; James H. Sullivan, M.D., Columbus, Vice Chairman; William E. Huger, M.D., Atlanta; Charles D. Wray, M.D., Augusta; W. John O'Shaughnessey, M.D., Macon, and Franklyn P. Bousquet, Jr., M.D., Savannah.

SECRETARY MAG BENEVOLENT FOUNDATION

Earnest C. Atkins, M.D.

Fortunately the Benevolent Foundation has had little activity in helping members in need. Our present bank balance is $6,527.00.

The Foundation continues to serve some needs of our members. It is well-established and will continue to grow.

This recommendation is made in order to keep the Foundation viable and in a position of future service.

RECOMMENDATION

Continuation of $1.00 per year for each member going to the Benevolent Foundation so when the need arises, the challenge can be met.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee feels that the balance in this Fund is ample at the present time and recommends that this recommendation be not approved.

HOUSE OF DELEGATES ACTION—Disapproved the recommendation of the Reference Committee, thus approving the recommendation of the Secretary regarding the MAG Benevolent Foundation.

SECRETARY GEORGIA MEDICAL CARE FOUNDATION

Earnest C. Atkins, M.D.

Although a separate report is given, a few comments about the GMCF are in order. First, our hat goes off to John R. McCain, M.D., board member, who headed the self evaluation study. He worked hard and long on this and put the emphasis where it belongs—"Excellence in Patient Care."

The GMCF has shown maturity and a sense of responsibility in reporting to the MAG Executive Committee, physicians whose pattern of practice is below acceptable standards.

There is a close liaison between the MAG and the GMCF that I hope to see continue indefinitely.

When GRMP leaves the Headquarters Office Building, I think we should give careful consideration to housing the Foundation under our roof.

RECOMMENDATION

Direct the Council to make every effort to renovate the Headquarters Office space vacated by RMP to the Georgia Medical Care Foundation's needs and move it back home. This will continue the close relationship that presently exists between MAG and GMCF.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this recommendation.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Secretary.

SECRETARY
HEADQUARTERS OFFICE

Earnest C. Atkins, M.D.

Our Headquarters staff has not increased over the past year, but the staff's activities have definitely increased. Each employee in his own way should be dedicated to serving the members and their patients, because without the membership, we would not require an MAG staff. Also, a primary, but often forgotten goal is the recruitment of new members.

The total personnel at MAG in the various related activities is 153. A breakdown is as follows:

	1973	*1974*	*1975*
GRMP	27	27	26
CHAMPUS	18	25	48
MAG	18	18	18
GMCF	33	33	47

The MAG figure includes Constitutional Secretary and Treasurer and Editor of *JMAG*.

The programs and projects continue to increase and function smoothly in a manner that reflects credit to the medical profession and its association.

Again, service to our membership should be the number one priority.

WATS LINE

The incoming toll-free service has been of great value between the members and the headquarters office. Adequate records of outgoing long distance state calls should be kept and reported to the Finance Committee in 1977 so an outgoing WATS line can be evaluated for its feasibility.

RECOMMENDATION

The incoming WATS line has met with great success. Direct the staff to evaluate the state outgoing long distance calls and install a state-wide outgoing WATS Line when economically feasible.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this recommendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary.

SECRETARY
MEMBERSHIP DUES

Earnest C. Atkins, M.D.

RECOMMENDATION

Continue to operate the MAG economically and effectively, but support the dues increase recommended by the Council. Incorporate a sliding dues scale for members entering and retiring from practice:

1st year in practice—⅓ dues
2nd year in practice—⅔ dues
3rd year in practice—full dues

At age 61, begin decreasing dues 10 percent each year until age 70, when life membership without dues is awarded.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends the original recommendation be not approved and approval of the following substitute drafted by the Committee: "Continue to operate MAG economically and effectively. Incorporate a sliding dues scale for members entering practice for the first time in their specialty. Each of these individuals must be approved by the Secretary and the Treasurer of MAG. The dues scale is:

1st year in practice—1/3 dues
2nd year in practice—2/3 dues
3rd year in practice—full dues

Also incorporate a sliding dues scale for older physicians who have been members of MAG for a minimum of 10 years. At age 66, begin decreasing dues 20 percent yearly each year until age 70, when life membership is awarded.

HOUSE OF DELEGATES ACTION—Delegate F. W. Dowda moved with appropriate second that the words "For the first time in their specialty" be deleted from the 2nd sentence of the Substitute Recommendation proposed by the Reference Committee.

The second sentence would then read "Incorporate a sliding dues scale for members entering practice." The House then adopted the Secretary's recommendation as amended.

REFERENCE COMMITTEE F

TREASURER

Carson B. Burgstiner, M.D.

Once again, let me express my gratitude to the Medical Association of Georgia for the privilege of serving as your treasurer for the year 1975-76. I have enjoyed working hand in hand with so many dedicated, unselfish and self-sacrificing physicians, working for a better medical association.

These are changing times with economic upheaval, rising inflation, escalating costs and increased unemployment. We must and will meet the challenge.

The handwriting is on the wall. The Finance Committee and Reference Committee have a tremendous responsibility this year. With local medical society and AMA dues increasing, we experienced a deficit budget in 1975-76. We are in need of a new building or a drastic upgrading of our present facilities. Salaries of our MAG staff are in need of sizeable adjustment. Governmental programs and spending have been curtailed. Our own new proposed programs, offered by our innovative and excellent secretary, Dr. Earnest Atkins, include specialty society services, a legal fund, computerization of members' files, continuing medical education programs, etc. These require additional funding. In short, you can look for a substantial increase in dues this year. We must operate from a balanced budget, and in order to have an effective and efficient organization, we must pour the financial fuel to the fire. Our success financially in these troubled times is attributable to our Director of Finance, Mr. L. B. Storey, Jr. and the expertise of Dr. "Tex" Eldridge, our Chairman of Finance. I appreciate their untiring efforts on behalf of the association. My respect and admiration to Jim Moffett and his staff for the tremendous amount of work they generate in running our association. Many thanks for the extra hours and myriad administrative duties you perform.

It saddens me to see two of our stalwarts, men of





Enjoying the champagne GaMPAC Brunch, with background music by a Dixieland band, are (L-R) Dr. and Mrs. LaMar McGinnis of Decatur, Mrs. Edgar Woody, Jr. of Atlanta, and Carson B. Burgstiner, M.D. of Savannah. Other delegates and their wives (R) sample the selection from the buffet table.

conscience and grace, Dr. "Red" Chambers and Dr. John Atwater, step down this year after long and distinguished careers. Filling their shoes will be difficult.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that this report be received for information.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer.

SUPPLEMENTAL REPORT OF THE FIRST VICE PRESIDENT

W. Daniel Jordan, M.D.

At the annual session of MAG in 1975 my officer's report (Second Vice President) requested a report of grants and contracts applied for by MAG and its subsidiaries since 1969. This report is contained in the Delegates Handbook that was mailed to each delegate. Incredibly, MAG and/or its subsidiaries has received $1,672,842 in grants and contracts since June 1971, and equally as astounding, we have applied for almost $6 million since 1973. Admittedly, some of these applications overlapped with themselves and with some grants received, but one must consider where we might be had we received even one half of the grants. The purpose behind this request was an effort to determine if MAG was becoming dependent upon federal funds for its existence.

A second recommendation, which was disapproved, was that MAG not apply for further federal monies until this report was forthcoming. Since the 1975 House of Delegates, MAG and/or its subsidiaries have applied for an additional $440,893 of federal money to carry out research activities. One of these, the grant from AMA for the study of prison health care, provides a vivid example of the manner in which federal money is utilized to support private organizations for an apparent public interest.

The Department of HEW awarded a grant to AMA totalling $448,000 to study prison health care, apparently over a one year period. AMA then awarded six various states grants of $25,000 each to perform that function. This left AMA $298,000 in excess with which they might fund other projects and with which *to administer the grant*. In fact, since 1972 the American Medical Association has received over $2 million in federal funds for some form of grant project. It then is not too surprising to note the development of attitudes of cooperation and implementation of federal programs.

MAG is already rather heavily involved with contracts and grants emanating from various federal sources. As of February 29, 1976, the various federal agencies owed $210,307 to the Medical Association of Georgia. If I understand this correctly, this is money already expended by MAG and almost constitutes an account receivable. It has now become difficult to sort out the amount of money supplied to MAG by the various sources and differentiate the amount necessary for the operation of MAG and its activities as related to its membership. The functions of the employees of MAG become blurred with activities associated with various governmental programs (GRMP and CHAMPUS). I feel that this has been borne out as Council has attempted to analyze the budget and make judgments about the many expenditures. It would appear that the whole of MAG is subsidized to some degree by federal funds either directly by contracts (CHAMPUS and Medicaid) or on a basis of grants and that degree may approach 15 percent. Certainly, if that be the case, we are dangerously close to being beholden to the government. Past experience of the field of education would indicate this is indeed a dangerous practice and will lead to total subservience on our part.

It is difficult to understand why we would continue in this relationship. What are the advantages to MAG? Does this type of activity provide real benefit to MAG and/or our patients? When one realizes the attitude of government in medical care, it becomes impossible to defend this apparent symbiosis. In their legal brief filed opposing a legal test of the constitutionality of PSRO, the government stated:

"Patients whose medical care is provided by public funds have no constitutional right to whatever care their physicians, using the highest standards of medical practice, may judge necessary, or to obtain that care from a physician of their choice."

Does MAG want to associate with this attitude? I say no!

RECOMMENDATIONS

I, therefore, recommend that MAG in an orderly fashion disassociate itself with governmental contracts.

I further recommend that all activities with governmental agencies be maintained separately from MAG finances.

I further recommend that MAG not apply for any grants and/or contracts until its own financial status can be carefully clarified and stabilized.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that Recommendation 1 be not approved and approval of this substitute drafted by the Committee: Your Reference Committee recommends MAG attempt to disassociate itself from governmental contracts.

Your Reference Committee recommends that Recommendation 2 be not approved. Your Committee feels difficulties would be encountered in following standard accounting procedures.

Your Reference Committee recommends that Recommendation 3 be not approved. Your Committee recognized its inability to anticipate the future needs of MAG.

HOUSE OF DELEGATES ACTION—The House did not approve Recommendation 1 of the First Vice President but approved instead a substitute drafted by the Committee "Your Reference Committee recommends that MAG attempt to disassociate itself from government contracts. The House then voted to not approve Recommendation number 2 and not approve Recommendation number 3 of the First Vice President's Report.

SUPPLEMENTAL REPORT OF COUNCIL BUDGET

Fleming L. Jolley, M.D., Chairman

	Proposed Budget 6-1-76 to 5-31-77
INCOME	
MAG Dues	$824,625.00
Interest and AMA Refund	27,000.00
Parking	4,800.00
Journal	43,000.00
Newsletter	3,000.00
TOTAL INCOME	$902,425.00
EXPENSES	
Fixed Allotments	$140,310.00
Association Office	333,153.00
Related MAG Activities	33,250.00
Association Committees	99,776.00
Executive Committee Discretionary Fund	6,200.00
Executive Committee Contingency Fund	5,000.00
Council Contingency Fund (4 Percent of Budget)	30,902.00
Journal	58,355.00
Data Base Maintenance	4,500.00
Sinking Fund for Land Acquisition	45,812.50
Depreciation	
Building	15,000.00
Equipment	3,300.00
TOTAL EXPENSES	$772,558.50
Excess of Income over Expenses	126,866.50
TOTAL EXPENSES AND EXCESS INCOME	$902,425.00

REFERENCE COMMITTEE F

	Proposed Budget 6-1-76 to 5-31-77
FIXED ALLOTMENTS	
Interest on Mortgage	$ 33,500.00
MAG Retainers	
Attorney	15,600.00
Actuary	10,000.00
Other	6,680.00
President's Honorarium	2,400.00
Newsletter	7,050.00
Annual Audit	3,300.00
Taxes, Ad Valorem	13,000.00
Retirement Contribution	20,640.00
Retirement Trust Fee	540.00
Auxiliary-Health Careers	14,500.00
MAG Roster	6,500.00
GaMPAC	3,000.00
MAG Foundation	3,600.00
TOTAL FIXED ALLOTMENTS	$140,310.00
ASSOCIATION OFFICE	
Salaries	$248,862.00
Insurance	16,010.00
Payroll Taxes	13,616.00
Travel-Office	22,115.00
Maintenance	
Building	6,000.00
Equipment	2,800.00
Telephone	11,500.00
Postage	12,000.00
Office Supplies	7,300.00
Janitorial Service and Supplies	9,900.00
Dues and Subscriptions	1,250.00
Utilities	14,800.00
Sundry	200.00
Equipment Purchases	8,000.00
TOTAL ASSOCIATION OFFICE	$374,353.00
Less Reimbursable Expense	41,200.00
NET ASSOCIATION OFFICE EXPENSE	$333,153.00
RELATED MAG ACTIVITIES	
Travel	
President	$ 2,700.00
President-Elect	1,600.00
Past President	1,600.00
Executive Committee	3,300.00
Meetings, Exec. Committee and Council	2,000.00
WATS Line	3,600.00
AMA Meeting Costs	
Caucus Breakfasts	1,100.00
MAG Headquarters Suite	1,500.00
Southeast Hospitality Suite	900.00
Travel	
Delegates and Secretary to AMA Meetings	6,255.00

	Proposed Budget 6-1-76 to 5-31-77
Alternate Delegates and Treasurer to AMA Meetings	6,595.00
Interprofessional Council	125.00
AMSA Meeting	.00
AMSA to MAG Annual Session (4)	950.00
State Medical Education Luncheon	225.00
AMA Leadership Conference (2 M.D.s)	800.00
TOTAL RELATED MAG ACTIVITIES	$ 33,250.00

ASSOCIATION COMMITTEES

Standing Committees	
Annual Session	$ 9,160.00
Scientific Session (Budgeted with instruction that part of costs be defrayed by registration fee to physicians)	13,343.00
Research and Development	14,420.00
Special Committees	
Access to Health Care—Rural and Urban Health	1,625.00
Allied Health	30.00
Awards	750.00
Building and Land	
Communications	24,813.00
Disabled Doctors Plan	17,300.00
Education	1,440.00
Insurance, Professional Liability	75.00
Laboratory Quality	640.00
Legislation	
National	2,700.00
State	8,315.00
Liaison-Board of Human Resources	4,000.00
Liaison, Georgia State Medical Association	45.00
Maternal and Infant Health	100.00
Medical Aspects of Sports	500.00
Occupational Health	100.00
Peer Review	20.00
Quackery	400.00
TOTAL COMMITTEES	$ 99,776.00

CONTINGENCY AND DISCRETIONARY FUNDS

Executive Committee Discretionary Fund	$ 6,200.00
Executive Committee Contingency Fund	5,000.00
Council Contingency Fund	30,902.00

JOURNAL

Printing	$ 38,150.00
Salaries	13,920.00
Insurance	890.00
Payroll Tax	995.00
Engraving and Cuts	1,900.00
Postage and Copyright	2,000.00
Clipping Service	300.00
Mailing Labels	200.00
TOTAL JOURNAL EXPENSE	$ 58,355.00

REFERENCE COMMITTEE RECOMMENDATION—(Shown below in right hand column as a substitute budget.)

	Original from Council	*Reference Committee F Substitute*
INCOME		
MAG Dues	$824,625.00	$696,350.00
Interest and AMA Refund	27,000.00	27,000.00
Parking	4,800.00	4,800.00
Journal	43,000.00	43,000.00
Newsletter	3,000.00	3,000.00
TOTAL INCOME	$902,425.00	$774,150.00
EXPENSES		
Fixed Allotments	$140,310.00	$131,310.00
Association Office	333,153.00	327,153.00
Related MAG Activities	33,250.00	35,650.00
Association Committees	99,776.00	60,913.00
Executive Committee Discretionary Fund	6,200.00	5,000.00
Executive Committee Contingency Fund	5,000.00	5,000.00
Council Contingency Fund	30,902.00	25,000.00
Journal	58,355.00	58,355.00
Data Base Maintenance	4,500.00	4,500.00
Sinking Fund for Land Acquisition	45,812.50	.00
Depreciation		
Building	15,000.00	15,000.00
Equipment	3,300.00	3,300.00
TOTAL EXPENSES	$775,558.50	$671,181.00
Excess of Income over Expense	126,866.50	102,969.00
TOTAL EXPENSE AND EXCESS INCOME	$902,425.00	$774,150.00

	Original from Council	*Reference Committee F Substitute*
FIXED ALLOTMENTS		
Interest on Mortgage	$ 33,500.00	$ 33,500.00
MAG Retainers		
Attorney	20,600.00	20,600.00
Actuary	10,000.00	10,000.00
Other	1,680.00	1,680.00
Newsletter	7,050.00	7,050.00
President's Honorarium	2,400.00	.00
Annual Audit	3,300.00	3,300.00
Taxes, Ad Valorem	13,000.00	13,000.00
Retirement Contribution	20,640.00	20,640.00
Retirement Trust Fee	540.00	540.00
Auxiliary-Health Careers	14,500.00	14,500.00
MAG Roster	6,500.00	6,500.00
GaMPAC	3,000.00	.00
MAG Foundation	3,600.00	.00
TOTAL FIXED ALLOTMENTS	$140,310.00	$131,310.00
ASSOCIATION OFFICE		
Salaries	$248,862.00	$248,862.00
Insurance	16,010.00	16,010.00
Payroll Taxes	13,616.00	13,616.00
Travel-Office	22,115.00	17,115.00
Maintenance		
Building	6,000.00	6,000.00
Equipment	2,800.00	2,800.00
Telephone	11,500.00	11,200.00
Postage	12,000.00	12,000.00
Office Supplies	7,300.00	6,900.00
Janitorial Service and Supplies	9,900.00	9,900.00
Dues and Subscriptions	1,250.00	950.00
Utilities	14,800.00	14,800.00
Sundry	200.00	200.00
Equipment Purchases	8,000.00	8,000.00
TOTAL ASSOCIATION OFFICE	$374,353.00	$368,353.00
Less Reimbursable Expense	41,200.00	41,200.00
NET ASSOCIATION OFFICE EXPENSE	$333,153.00	$327,153.00
RELATED MAG ACTIVITIES		
Travel		
President	$ 2,700.00	$ 5,100.00
President-Elect	1,600.00	1,600.00
Past President	1,600.00	1,600.00
Executive Committee	3,300.00	3,300.00
Meetings, Exec. Comm. and Council	2,000.00	2,000.00
WATS Line	3,600.00	3,600.00
AMA Meeting Costs		
Caucus Breakfasts	1,100.00	1,100.00
MAG Headquarters Suite	1,500.00	1,500.00
Southeast Hospitality Suite	900.00	900.00
Travel		
Delegates and Secretary to AMA Meetings	6,255.00	6,255.00
Alternate Delegates and Treasurer to AMA Meetings	6,595.00	6,595.00
Interprofessional Council	125.00	125.00
AMSA Meeting	.00	500.00
AMSA to MAG Annual Session	950.00	450.00
State Medical Education Luncheon	225.00	225.00
AMA Leadership Conference (2 M.D.s)	800.00	800.00
TOTAL RELATED MAG ACTIVITIES	$ 33,250.00	$ 35,650.00

	Original from Council	*Reference Committee F Substitute*
ASSOCIATION COMMITTEES		
Standing Committees		
Annual Session	$ 9,160.00	$ 9,160.00
Scientific Session	13,343.00(*)	.00(**)
Research and Development	14,420.00	.00
Special Committees		
Access to Health Care-Rural and Urban	1,625.00	1,625.00
Allied Health	30.00	30.00
Awards	750.00	750.00
Communications	24,813.00	18,713.00
Disabled Doctors Plan	17,300.00	12,300.00
Education	1,440.00	1,440.00
Insurance, Professional Liability	75.00	75.00
Laboratory Quality	640.00	640.00
Legislation		
National	2,700.00	2,700.00
State	8,315.00	8,315.00
Liaison-Board of Human Resources	4,000.00	4,000.00
Liaison, Ga. State Medical Assn.	45.00	45.00
Maternal and Infant Health	100.00	100.00
Medical Aspect of Sports	500.00	500.00
Occupational Health	100.00	100.00
Peer Review	20.00	20.00
Quackery	400.00	400.00
TOTAL COMMITTEES	$ 99,776.00	$ 60,913.00
CONTINGENCY AND DISCRETIONARY FUNDS		
Executive Committee Discret. Fund	$ 6,200.00	$ 5,000.00
Executive Committee Contingency Fund	5,000.00	5,000.00
Council Contingency Fund	30,902.00	25,000.00
JOURNAL		
Printing	$ 38,150.00	$ 38,150.00
Salaries	13,920.00	13,920.00
Insurance	890.00	890.00
Payroll Tax	995.00	995.00
Engraving and Cuts	1,900.00	1,900.00
Postage and Copyright	2,000.00	2,000.00
Clipping Service	300.00	300.00
Mailing Labels	200.00	200.00
TOTAL JOURNAL EXPENSE	$ 58,355.00	$ 58,355.00

(*) Budgeted with instruction that part of costs be defrayed by registration fee to physicians.

(**) Budget .00, all of cost to be defrayed by registration fee to attending physicians.

Delegate James H. Sullivan of Columbus introduced a Minority Report to the Report of Reference Committee F advocating a dues increase of $125 per year. The Minority Report is as follows:

MINORITY REPORT OF REFERENCE COMMITTEE F

JAMES H. SULLIVAN, M.D. AND FRANK BOUSQUET, M.D.

Mr. Speaker: Dr. James H. Sullivan, Delegate from Muscogee County Medical Society and Second Vice President of your Association.

I rise to present a Minority Report filed by me and Dr. Frank Bousquet of Georgia Medical Society to the House of Delegates regarding the Budget of the Medical Association of Georgia and proposed dues increase (O/C 6-76).

We strongly disagree with some of the conclusions of Reference Committee F. We wholeheartedly approve of many of the monetary cuts in the budget. To delete some of the following would be a travesty on the Medical Association of Georgia. This budget has been studied in detail by the Finance Committee, the Executive Committee of the Council of MAG and the Council of MAG as well as Reference Committee F.

With regard to Reference Committee F, there were a number of members of this committee who had either attended only one study session of the budget or either attended no study session of the budget. We would like to call attention of the House of Delegates to the complete obliteration of:

1. *The Sinking Fund for Land and Ground Acquisition*—Time is fast approaching when we will be unable to afford our MAG Headquarters property due to increased taxes, inability to expand our facilities five to 10 years from now, the increase in burglaries, and subsequent rise in insurance. The price of land is escalating yearly and the longer we wait, the more we pay.

2. *MAGNET Conference*—Our reason for opposing this deletion is that it is an opportunity for socioeconomic education for new members and office staff personnel presented by this conference.

3. *Scientific Session of MAG*—We feel it is our obligation to continue with this program since we have involved the specialty societies with the stipulation that it be held separate from the House of Delegates, and that it be geared towards being a self-sustaining meeting by registration fees.

4. *GaMPAC Contribution*—This is a form of seed money without which GaMPAC could not have survived, and for which each of us in MAG owes a tremendous debt for their political activism.

5. *GMCF Benevolent Fund*—This is a fund set aside in a trust to help needy physicians and their families.

6. *Research and Development Funds*—We object strongly to complete destruction of Research and Development Funds. We should continue through medical education to inform MAG membership of medical knowledge, socioeconomic matters, medicolegal problems, peer review mechanisms, and audit information. MAG should lead this program of medical education which is in its infancy, instead of leaving this to the federal government, state government, or any other outside non-medical related institution or foundation.

7. We disagree with the Reference Committee in the cuts in many of our Association committees. This is where we involve our membership. If we cut committee funds drastically, each committee chairman has to come to Council or Executive Committee of Council begging for funds for a new or ongoing project.

8. The Reference Committee wishes to recommend a new dues structure for new members of the Association and also for the elderly physician still in active practice with which we wholeheartedly agree. However, if we follow this line of reasoning we see a further loss of income funds.

We think many of you would approve many of the cuts in the budget which were considered. This certainly is a time for austerity and efficiency.

The recommended dues increase of $90 is only sufficient to cover our budget for the next fiscal year. We believe that the majority of the membership of MAG do not want to hassle with the problem next year and each subsequent year of a dues increase of some $25 to $50 per year.

Look at the furor and discord that this present budget study and dues increase is causing in our House of Delegates. Do we need to produce this cacophony year after year in order to survive?

In view of the above comments, Mr. Speaker, it is the recommendation of this Minority Report to Reference Committee F that we ask the membership, through the House of Delegates, for a dues increase of $125 per year to obviate the necessity of a dues increase for at least a minimum of three years, with emphasis on austerity, planning and fiscal responsibility.

REFERENCE COMMITTEE F

HOUSE OF DELEGATES ACTION—The House of Delegates disapproved a recommendation of the Reference Committee that the budget presented by Council be not approved. A second recommendation of the Reference Committee calling for a substitute dues increase of $90 per member per year was also disapproved by the House. Delegate Dowda moved with an appropriate second that that portion of the Minority Report advocating a dues increase of $125 per year per member be adopted. Delegate John McCain of Atlanta moved to amend the Minority Report by inserting the phrase "with the hope that such increase will" in the last sentence of said report so that the last sentence then reads "In view of the above comments, Mr. Speaker, it is the recommendation of this Minority Report to Reference Committee F that we ask the membership through the House of Delegates for a dues increase of $125 per year with the hope that such increase will obviate the necessity of another dues increase for at least a minimum of three years with emphasis on austerity planning and fiscal responsibility." This amendment was adopted by the House. The House then adopted the motion proposed by Delegate F. W. Dowda calling for a dues increase of $125 per year. The vote on the Dowda motion was 89 for adoption and 51 against. Delegate F. G. Eldridge then moved the adoption of Supplemental Report of Council (O/C: 6-76)—as the budget was presented by Council to the House of Delegates. This motion was duly seconded and on vote was adopted 97 votes for and 32 votes against.

RESOLUTION 4-76
BALANCED BUDGETING

L. Newton Turk, III, M.D.

WHEREAS, the MAG Council has, in past years, approved deficit budgets, and

WHEREAS, surplus funds have been used to offset these deficit budgets, and

WHEREAS, such deficit budgeting cannot continue in future years, not therefore be it

RESOLVED, that the MAG adopt balanced budgeting as a basic MAG policy, and be it further

Resolved that this policy be put into effect with fiscal year 1976-1977 with no further deficit spending.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends the original Resolution be not adopted and recommends adoption of the following Resolution drafted by the Committee:

RESOLVED, that MAG adopt balanced budgeting as a basic MAG policy and that this policy be put into effect with the fiscal year 1976-1977.

HOUSE OF DELEGATES ACTION—Adopted Resolution 4-76 as amended by the Reference Committee.

RESOLUTION 13-76
DEFICIT BUDGETING AND SPENDING

DeKalb Medical Society Delegation

WHEREAS, the Medical Association of Georgia is established as a non-profit organization for the purpose of "promoting the science and art of medicine and the betterment of public health as provided for in the By-laws," and

WHEREAS, the MAG is dependent primarily on dues paid by its members for its operating income, and

WHEREAS, the MAG has become increasingly involved with administrative mechanisms designed to facilitate implementation of various governmental programs (e.g., CHAMPUS, GRMP, Health Data Systems of HEW, etc.) and such involvement has necessitated increasing administrative capabilities by the MAG, and

WHEREAS, the progressively increasing costs of the MAG administrative structure has now resulted in a deficit budget of more than $331,000 for fiscal year 1976-77, with salaries and payroll taxes alone accounting for more than $260,000, and

WHEREAS, this deficit budgeting concept has necessitated that this Annual Session mandate a dues increase on the membership, therefore be it

RESOLVED, that the House of Delegates establish as official policy that future deficit budgeting and spending be prohibited beginning with fiscal year 1976-77.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that the original resolution be not adopted and adoption of the following substitute resolution drafted by the Committee: "That the House of Delegates establish as official policy that future deficit budgeting be prohibited beginning with fiscal year 1976-77."

HOUSE OF DELEGATES ACTION—Adopted Resolution 13-76 as amended by the Reference Committee.

Chairman Blair expressed his appreciation to the members of the Reference Committee for their time and effort and thanked others concerned for assistance rendered to the Committee and for the preparation of this report.

REPORT OF REFERENCE COMMITTEE A

CHARLES W. McDOWELL, JR., M.D., *Chairman*

Chairman McDowell reported to the House that all reports and resolutions referred to Reference Committee A had been considered by the Committee which met at 2 p.m. in Colony Hall at the Holiday Inn on Jekyll Island on Friday, April 9, 1976. Members of the Reference Committee present included Charles W. McDowell, Jr., M.D., Decatur, Chairman; O. E. Ham, M.D., Savannah, Vice Chairman; Claude A. Boyd, M.D., Augusta; William J. Smith, M.D., Brunswick; John Shellack, M.D., Atlanta; and Joseph Stubbs, M.D., Valdosta.

RESOLUTION 17-76
HOUSE OF DELEGATES TIMETABLE

Glynn County Medical Society

WHEREAS, in recent years the length of sessions of the House of Delegates seems to have been constantly increasing; and

WHEREAS, the late hour at which the Second Session of the House adjourns on the Sunday of the Annual Meeting works a hardship upon those delegates who live at a great distance from the city in which the meeting is held and requires that some delegates depart before the House has completed its deliberations in order to obtain transportation to their homes; and

WHEREAS, there is a considerable volume of non-controversial business which must be conducted in the Second Session of the House, NOW THEREFORE BE IT

RESOLVED, that the Speaker of this House and the Council of the Medical Association of Georgia be directed to arrange the agenda of Annual Sessions of this House in years subsequent to this so as to provide for the consideration of matter judged to be non-controversial in nature at a Second Session conducted on Saturday of the week of the meeting, leaving controversial matters for a Third Session on Sunday, and hoping that the House will be enabled to adjourn *sine die* by noon on Sunday.

REFERENCE COMMITTEE RECOMMENDATION —This resolution deals with the House of Delegates' timetables and meeting schedules. Your Reference Committee recommends that the resolved portion of Resolution R-17 not be adopted and the following be adopted as a committee substitute:

RESOLVED, that the House of Delegates appreciates the need for methods to be devised to expedite House sessions, that the question of revising schedules be referred to the MAG Committee on Annual Session for evaluation, and that the Committee report its findings to Council for appropriate action prior to the next House of Delegates meeting.

HOUSE OF DELEGATES ACTION—Adopted Resolution 17-76 as amended by substitute by the Reference Committee.

RESOLUTION 10-76
TITLE OF MAG CHIEF EXECUTIVE

DeKalb Medical Society Delegation

WHEREAS, the House of Delegates will be considering recommendations from the Ad Hoc Committee on Organizations and Functions concerning changes in titles in elected officials; and

WHEREAS, there is a trend among large trade and professional associations (including the American Medical Association) to title the chief executive as Executive Vice President instead of Executive Director, and

WHEREAS, the title of Executive Vice President lends more prestige to the position; therefore, be it

RESOLVED, that the Medical Association of Georgia change the title of its chief executive position from Executive Director to Executive Vice President.

REFERENCE COMMITTEE RECOMMENDATION

—This resolution concerns itself with changing the title of MAG's chief executive. Your Reference Committee recommends the adoption of this resolution.

HOUSE OF DELEGATES ACTION—Disapproved the adoption of Resolution 10-76.

PRESIDENT-ELECT

Fleming L. Jolley, M.D.

Thank you for the opportunity to serve this organization as its forthcoming president. Thank you for the dedicated gentlemen who have served in various capacities on Council. They have been willing to deal with the various issues in frequent Council meetings. Council has met more times this year than in any previous year to our knowledge. Debate has been intense and quite lengthy at times. If the actions of Council do not reflect the wishes of the House of Delegates, it behooves this House to give serious thought to other alternatives.

Continued effort on the part of the MAG membership in their voting rights to place councilors who truly represent the desires of the membership must be accomplished.

During the year I shall continue to visit as many of the societies as schedules permit and to encourage the new President-Elect and other officers as well as staff to do likewise. Suggestions and recommendations are always welcomed in improving the responsiveness of this organization to its membership.

I encourage each of you, and particularly the younger members, to acquaint themselves with the committee activities in their reports. Volunteering for committee appointments to actively represent your ideals will assure a most representative organization.

Again, thanks to our entire staff for the many hours of dedicated work on behalf of the physicians of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed the annual report of the office of the President-Elect and recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect.

FIRST VICE PRESIDENT

W. Daniel Jordan, M.D.

The year 1976 culminates my term of office with MAG. The past two years have been relatively short but at times interminable, usually at the end of a six hour Executive Committee meeting. The two years spent on Council and its Executive Committee have served to reinforce some prior opinions about the organizational framework of MAG. I should add that this time has been quite informative and certainly has led to the development of other opinions.

Allow me to state this disclaimer at the outset. I have an axe to grind, but it is not a personal one. As an elected official of MAG, I feel I have a definite responsibility to report the situation that exists as I see, hear, and interpret the events. The intent is not to chastise individuals at all but simply to air the situation so that the members of MAG have the opportunity to act as they see fit.

It has been stated both directly to me and by others

REFERENCE COMMITTEE A

that MAG does not reflect the feelings and philosophy of its members. My experience with MAG has led me to the following conclusions: The Executive Committee of Council reflects the feelings of the majority of the Executive Committee. The Council decisions reflect the feelings of the majority of Council, and the decisions of the House of Delegates reflect the wishes of the majority of the House of Delegates. If there be a discrepancy between the actions of the Executive Committee of Council and the feelings of the membership, the blame for this discrepancy can only rest with those individuals who have voted the various officials into office. If a member is not aware of the background philosophy of the candidate then, unfortunately, the member can blame only himself if he is displeased with the actions of the elected official that he supported. This type of thinking leads me into my chief complaint about MAG, but that is getting ahead and first I would like to recite the events of a small incident in the everyday life of MAG that illustrates another aspect of MAG's problems.

In April, 1975, the House of Delegates of MAG directed that application for a PSRO Planning Contract be made 15 days prior to the deadline for a physician priority consideration. In April, 1975, that deadline was January 1, 1976. On or about December 18, 1975, the application was finalized and mailed. On December 19, 1975, Congress passed Social Security amendments extending the deadline for physician priority to January 1, 1978, and the bill was signed into effect by the President on December 31, 1975. At the January, 1976, meeting of Council it was reported that the application for the planning contract had been submitted on time and had been acknowledged by HEW, with no statement about the recent law extending the deadline. Following this announcement it was then reported (by me) that the deadline had been extended to January 1, 1978, and motion was made that the application be withdrawn. Subsequent action was to place the application in suspension until further notification by MAG. All of this sounds to be in order, but the first knowledge that I received about a change in the priority deadline came from the MAG office on December 18, 1975, prior to the passage of the bill containing the Social Security amendments. Separate research on my part confirmed the amendments becoming law. This resolves itself down to one major question. If there was knowledge in the MAG office that the possibility of an extension of the deadline existed, why then was this information not pursued to its fullest, so that Council would be notified at its January meeting? I am left with the assumption that if I had not objected at the January Council meeting, then MAG's application would still be in effect. I present this as an example of activities that are carried out by MAG office that do not seem to reflect the directives of its members.

It is this floundering, movement without a purpose, riding the crest of the waves, rolling before the wind, that is the prime subject of my report. MAG has no permanence. It has no solid foundation from which to project its activities. Placed in everchanging world, without its permanence, it then flounders. Its activities become pragmatic, expedient, frustrating to both mem-

ber and staff, unrecognizable by the public, and held in contempt by those people who attempt to control public opinion (legislators and press). This is reflected in our legislative activity, on a state and national level, as we attempt to be on the winning side, regardless of its position. We complain about governmental intervention on one hand and then seek legislative mandate for protection. It is indeed a paradox that as physicians, we are held in high individual esteem, yet as an organization we are virtually ignored (e.g., the DHR Provider Agreement).

Is MAG salvagable? Certainly, it is. How? By establishing its permanence first, then beginning its activities from that basis, keeping that permanence as the foundation and guidelines for its efforts. The beginnings of this must be at the lowest level of MAG (the individual members), institution of a philosophy from the top is effective only as long as the top is in control. But if this begins at the bottom, the top position then reflects the foundation. If the members of MAG believe that their feelings are not represented by the hierarchy of the organization then hopefully they will set about getting their house in order.

It has been a privilege to serve as an officer of this organization. My tenure has been during a frightful and dangerous time for organized medicine. Unfortunately, unless organized medicine can establish its permanence, I'm afraid these times will continue.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that this report be received for information.

HOUSE OF DELEGATES ACTION—Received for information.

COUNCIL

Fleming L. Jolley, M.D., Chairman

Council has met June 7, 8, 1975, July 13, 1975, August 17, 1975, September 13, 14, 1975, November 9, 1975, January 10, 11, 1976, and prior to annual session will meet March 14, 1976, and April 8, 1976. Attendance has been very good at these meetings.

There were two called meetings centering attention to Medicaid problems resulting in the suit which at this time has been filed but as yet unheard by a judge.

The third called meeting reflected upon the ethics of the application for PSRO after considerable time was spent on the PSRO in the September meeting. At this time, the PSRO application has been withdrawn upon extension of the deadline for two years in December, 1975.

The professional liability insurance program has received considerable attention and the insurance and legislative committees have led an active effort to secure legislative relief in the current General Assembly.

You are receiving the MAG *Newsletter* approved by Council. The "Disabled Doctors" plan was approved with an eight month funding of $4,109. The MAG printshop was approved and is "gearing up" with the purchase of equipment totaling some $50,000.

By September, 1975, GaMPAC membership had reached 1,381. The "largest number ever" represents only 850 physicians and 531 auxiliary members.

Council approved the request of Muscogee County to enter an amicus curiae brief request in the Court of Appeals of Georgia.

MAG membership files are now computerized at least for five months. Cost is $2,500. ($500/month for computer time and staff.)

"CONTROL," which stands for Committee on National Trends, Ramifications and Origins of Legislation," was commended in its concept and encourages members who agree to this concept to join.

Council reviewed and received for information the report on organization and functions being sent to the House of Delegates.

Dr. L. C. Buchanan was praised for his appearance in Washington before the Subcommittee on Health of Ways and Means Committee in presenting recommendations for PSRO amendments and for "streamlining" the '76 House of Delegates' session.

Budgetary considerations relative to the need of an increased dues structure, forthcoming in February, 1976, will be reviewed by Council in March, 1976.

HSA—weekly updates and progress reports at each Council meeting—is moving. Dr. Sammons, Executive Director of AMA, indicates AMA contemplates legal action.

Each committee report to the 1976 House of Delegates has been assigned to members of Council for review and report. Representatives of Council will attend the reference committees to aid in their deliberations.

REFERENCE COMMITTEE RECOMMENDATION —The report of Council is recommended for approval by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of Council.

SECRETARY MEMBERSHIP

Earnest C. Atkins, M.D.

The Medical Association of Georgia has had another banner year. It continues to be apparent that the activities of the MAG, both in number and complexity, are rapidly accelerating. The leadership ability of the members, Council, Executive Committee, Committee Chairmen, Headquarters Office Staff, CHAMPUS Staff, and the staff of the Georgia Medical Care Foundation continues to be more and more obvious. It is a genuine pleasure to serve with such dedicated and effective people.

Membership Report

	1971	*1972*	*1973*	*1974*	*1975*
Active	3,373	3,418	3,456	3,738	3,741
Active I&R				24	40
DE-1	39	62	63	59	65
DE-2	55	31	21	19	15
DE-3	53				
DE-4	17	15	10	11	12
Life	170	184	179	167	191
Associate	76	106	111	133	99
Service	59	60	65	55	62
Honorary	1	1	1	1	1
Affiliate	1	1	1	1	2
Student	2	3	1	2	2
	3,846	3,881	3,917	4,210	4,230
AMA Membership					3,259

The membership of the Medical Association of Georgia continued its upward climb during the year 1975. The five year comparison in active members shows a steady but slight increase from 1971 of 3,846

to 1975 of 4,230. This is an increase of 384 members or nearly 10 per cent.

Also, our MAG and AMA membership are at an all-time high, but as can be seen above, there is a serious gap in membership from the county to the AMA level.

There are 6,300 physicians in Georgia eligible for membership in MAG. Only 4,230 or 67 per cent are MAG members and 3,259 or 52 per cent are AMA members.

If we are to survive, all physicians must support organized medicine. As the membership age in organized medicine increases, we must especially interest the younger physicians, residents, interns and medical students in a vital part of their future.

RECOMMENDATION

Direct the Executive Committee to have the membership and non-members computerized so that the Membership Committee will have access to personalized solicitation through the specialty societies, local medical societies, hospitals, etc.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary.

COMMITTEE ON COMMUNICATIONS

Marvyn D. Cohen, M.D.

(Recommendation 1 referred to Reference Committee D, Recommendations 2-5 considered below.)

The Communications Committee's objectives are continuing to be met with good results.

Our efforts with the State Composite Board of Medical Examiners continue to bear fruit. The Committee staff liaison has met regularly with the Board and has, on behalf of the Association, provided refreshments and membership information to all physicians taking the FLEX examination.

MAGNET 1975 could in some terms be considered successful. We were able, once again, to put together an outstanding program of broad interest.

On the negative side, the Committee was advised rather than consulted about dates and location of the conference. MAGNET was placed in direct conflict with two other meetings. The predictable result was a drop in attendance from 275 in 1974 to about 130 in 1975. MAGNET has become too important in the Association meeting schedule to get less than the maximum in attendance potential and programs.

The Committee plans to develop another outstanding practice management seminar in the fall of 1976.

Through staff, we produced our second set of public service radio health spots. The 10 spots were distributed to Georgia's over 200 radio stations and have gained wide support in terms of content and quality of production.

Overall, media relations continues to be a strong aspect of Association communications activities. In 1975 we had over seven hours of television program time and many spots on newscasts from over the state. Our clipping file of print news is quite large and reflects the favorable image MAG projects to the media.

The Committee, again through staff, has worked closely with the Composite State Board of Medical Examiners so we could communicate with new member prospects. We have provided refreshments for doctors taking the FLEX examination, taking this opportunity to distribute literature and talk to prospects on an individual basis.

Through the staff and Committee we have presented the third practice management workshop for senior residents. This year we had 35 new doctors in the seminar. Since our Director of Education is now established with the Association, I think it appropriate that he take over the management of this seminar after this year. There is a seminar scheduled for late April 1976 which he can follow.

RECOMMENDATIONS

1. That responsibility for the residents workshop be assumed by the Assistant Executive Director for Education after the 1976 seminar.
2. That the Association continue its full support for viable communications plans developed by the Committee.
3. That MAGNET return to autonomous and free standing status and continue receiving support from the Association.
4. That the Committee be allowed to continue to develop our radio public service announcements.
5. Since this committee should be one of the most important the Association has, it is recommended that the President hand-pick the chairman. It is further recommended that the chairman be invited to all major meetings of the Association (Council, Executive Committee, etc.) so the Committee's charge, to provide advice and assistance, can be fulfilled.

REFERENCE COMMITTEE A

REFERENCE COMMITTEE RECOMMENDATION —Reference Committee A was requested to review recommendations 2, 3, 4 and 5 of this report. Your Reference Committee recommends approval of recommendation 2, concerning itself with the Association giving full support to viable communications efforts developed by the committee. Your Reference Committee recommends disapproval of recommendation 3, and would offer a substitute recommendation stating that the Medical Association of Georgia New Education and Training Conference dates should be selected by the Communications Committee, and should continue to receive support from the Association if financially feasible. Your Reference Committee recommends approval of recommendation 4, with the following amendment. The Committee amendment would be added at the end of amendment 4 of the report, and would state as follows: "All messages presented in the public service announcements should be consistent with MAG policy and be continued if financially feasible." Your Reference Committee recommends disapproval of recommendation 5 since the current method of committee selections and chairman selections is adequate.

HOUSE OF DELEGATES ACTION—Adopted the report of Committee on Communications as amended by Reference Committee. Specifically the House adopted Recommendation 2, Recommendation 3 as amended by substitute, Recommendation number 4 as amended and disapproved Recommendation number 5.

COMMITTEE ON MENTAL HEALTH

William S. Davis, M.D.

This past year has been a rather active one for the Mental Health Committee. Once again our primary activity was in the legislative area. The committee considered and made recommendations on House Bills 152, 191 and 393. In House Bill 152 we opposed the Drug Substitution Bill because we could not be certain that being generically the same was, in fact, the same as being equivalent.

House Bill 191, Psychologist Insurance, was supported in principle but the committee supported the MAG position of not supporting legislation which would require specific coverage to be provided by an insurance company.

House Bill 393 was relating to the Keogh Plan and was supported by the committee. The Mental Health Committee considered at length the proposed mental health services legislation and represented the MAG and the public on the proposal.

In summary, the committee recommended that any new legislation mandate mental health care for Georgia and insure the provision of basic mental health services to all the citizens of the state.

Finally, the committee met with representatives of Blue Cross to recommend changes in the forms supplied to the Federal Employees Program. It was widely felt that the information on these forms represented a major breach of confidentiality between a physician and his patient. The alterations were made in a spirit of cooperation and the new form was felt, by the committee, to represent a major advance in preserving confidentiality and at the same time providing the carrier with information necessary to make a valid decision on the claim.

RECOMMENDATIONS

1. It is recommended that, if possible, a liaison be established with the Division of Mental Health in order to establish a dialogue that would promote mutual trust and understanding as well as give the Medical Association the opportunity to be in a constructive rather than reactionary position on matters relating to mental health in the state.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed the annual report of the Committee on Mental Health and would recommend approval of their recommendations with the following amendment: It is recommended that, if possible, a liaison be established between the MAG Mental Health Committee and the Division of Mental Health of the Department of Human Resources, and, further, that the chairman of the Mental Health Committee should become a member of the Department of Human Resources Liaison Committee for the coordination of activities. This section should be inserted in front of the language beginning on line 39, with the words "in order to," and continuing through the rest of the recommendation as previously stated in the Committee report. Therefore, the recommendation recommended by the Reference Committee would read as follows: "It is recommended that, if possible, a liaison be established between the MAG Mental Health Committee and the Division of Mental Health of the Department of Human Resources. Further, the chairman of the Mental Health Committee should become a member of the DHR Liaison Committee for the coordination of activities in order to establish a dialogue that would promote mutual trust and understanding as well as give the Medical Association the opportunity to be in a constructive rather than a reactionary position on matters relating to mental health in the state."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Mental Health as amended by the Reference Committee.

COMMITTEE ON LABORATORY QUALITY

Richard E. Dubois, M.D.

During the past year, the Committee on Laboratory Quality began the first phase of establishing a voluntary self-evaluation and proficiency testing program to assure quality laboratory work by Georgia physicians. In September, a letter from the chairman of the committee was mailed to local and county medical societies and one from the Secretary of MAG was mailed to MAG membership. Each of these letters encouraged physicians doing laboratory work for their own patients to voluntarily participate in existing commercial proficiency testing programs. Materials on the proficiency testing programs of the American Society of Internal Medicine and the College of American Pathologists were mailed to MAG members in November.

In February, the committee met with the Laboratory Advisory Council to the Board of Human Resources. In contemplating a change in the Laboratory Licensure Law to include review of physicians' office laboratory work the Board requested that a survey be conducted to determine what laboratory work was being done in Georgia, by whom, and which methods of quality control are being applied. The Advisory Council met with the Committee on Laboratory Quality to determine the type of questionnaire that should be mailed. Copies of the questionnaire, with a cover letter from the President of MAG, were mailed to half the membership in July. Of the 2,121 questionnaires which were mailed, 1,076, or 50.7 per cent, were returned to the Department of Human Resources. Of these respondents, 633, or 58.8 per cent, reported they perform some type of laboratory work in their offices. Of the 633 physicians performing laboratory work, 315 reported that they use at least one method of quality control; but only 98, or 15.5 per cent, reported they participated in at least one proficiency testing program. Of these 98 physicians, 15 subscribed to ASIM, 45 to CAP, 2 to AAB, 13 to CDC, 4 to Sunderman, and 46 to the State. The Department of Human Resources has all results tabulated in a report of the survey titled "A Statewide Survey of Office Laboratory Practices Among Membership of the Medical Association of Georgia," September 29, 1975.

Federal and state legislation to review the lab work performed by physicians for their private patients is still pending. The committee feels that some alternative to government intervention should be pursued. Thus, the committee proposes conducting a feasibility study on ways to assure quality performance through a voluntary program to assure that lab work performed by Georgia physicians is of high quality.

RECOMMENDATION

1. That the Medical Association of Georgia continue

to develop and monitor a voluntary program of quality assurance for physicians' office laboratories.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed the annual report of the Committee on Laboratory Quality and recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Laboratory Quality.

DISABLED DOCTORS PROGRAM

G. Douglass Talbott, M.D.

The Disabled Doctors Plan activated in the fall of 1975 was the result of a careful year's study plan by the Disabled Doctors Committee of the Medical Association of Georgia. This study encompassed visits to the West Coast for the San Francisco National Meeting of the American Medical Association on chemically dependent and ill physicians as well as visits to Pennsylvania, Maryland, and Ohio. Since September, 17 physicians have become involved in this program. Another meeting in February in Chicago has been held by the American Medical Association's Mental Health Division in view of the large numbers of physicians involved in the Georgia program and the current activities of the Disabled Doctors Committee. At this meeting, an international symposium on the Disabled Doctors Program, using Georgia's plan as one of the models, sponsored by the American Medical Association, is in the planning state.

CURRENT PHYSICIAN-PATIENT STATUS

The census of the Disabled Doctors Program of the Medical Association of Georgia as of February, 1976 is as follows: currently in treatment—5; contacted awaiting disposition—8; completed treatment—4.

Treatment has varied from residence at rehabilitation centers such as Willingway Hospital in Statesboro, Chitchat Farms in Pennsylvania, Hazeldon in Minnesota to 28 day attendance in the DeKalb Addiction Program to weekly visits at the disabled doctors evening meetings. All physicians contacted by the Disabled Doctors Committee have voluntarily participated except for one physician whose case has been referred to the Professional Conduct and Ethics Committee. Contact with the Disabled Doctors Committee by these 17 physicians has been accomplished by a variety of sources, mainly peer physicians, spouses, and hospital staff and administrators. As disabled doctors complete the treatment course as outlined by our program, they become valuable team members of the advocacy committee to help the sick and lonely doctor who has not as yet accepted his disease or is having difficulty in getting into treatment. As such he or she should become a part of the Physician's Consultant Committee. There are presently several doctors who fit this category. (See Recommendation 2.)

CURRENT ACTIVITIES OF THE DISABLED DOCTORS COMMITTEE

Aside from the daily contact activities with reported and in-treatment disabled doctors, there are a number of other activities of this committee:

1. Weekly disabled doctors meeting—Every Wednesday night at the Central DeKalb Mental Health Center, a large group of disabled doctors and their spouses meet. Initially, they meet as a group and then split into the disabled doctor and spouse groups. Mutual problems are discussed. A large contingent of this group (20) are going March 4 and 5 to the International Doctors in A.A. meeting in New Jersey.

2. The March issue of the *Journal of the Medical Association of Georgia* has been largely devoted to the Disabled Doctors Program and the committee has contributed heavily to its publication.

3. The American Medical Society of Alcoholism is holding a national meeting in May in Washington and the Medical Association of Georgia's Disabled Doctors Program will be presented and discussed.

4. Medical Student Teaching—At Emory Medical School, freshmen, sophomore, and junior medical students are lectured and dialogued concerning the Medical Association of Georgia's Disabled Doctors Plan. In addition, junior students spend a clerkship at the DeKalb Addiction Clinic and a third year psychiatrist resident is currently involved with our program.

5. Two disabled doctors are completing a year's program with the DeKalb Addiction Clinic where they have phased from a patient status to staff. They have been supported by the Vocational Rehabilitation Program of Georgia.

6. Several meetings with the staff and members of the Board of Medical Examiners has been accomplished. The Board relates to the Disabled Doctors Program in being the body who can restore the license of our sick physicians who have successfully undergone rehabilitation. Also, they can restrict practice until treatment is secured. In addition, we have seen physicians referred directly from them. Continued and close liaison is needed. (See Recommendation 3.)

RECOMMENDATIONS

1. Continue MAG philosophical and financial support of the program.
2. Expansion of the Disabled Doctors Physician's Consultant Committee.
3. Continued and expanded efforts to establish a mutually beneficial relationship with the Board of Medical Examiners.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has reviewed the annual report of the Disabled Doctors Program. Your Reference Committee recommends approval with commendation of recommendation 1 of this report. Your Reference Committee recommends approval of recommendation 2. Your Reference Committee would offer as an amendment by substitution for recommendation 3, to read as follows: "Continued and expanded efforts to establish mutually beneficial relationships between the Board of Medical Examiners and the MAG Executive Committee in concert with current Association policy."

HOUSE OF DELEGATES ACTION—Delegate Robert Van de Wetering moved to amend recommendation 2 of the Disabled Doctors Program Report by the addition of the following language. "As presently structured, the Disabled Doctors Physicians Con-

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sultant Committee reports to Disabled Doctors Committee. We recommend inclusion of a psychiatrist member of the MAG Mental Health Committee on the Disabled Doctors Committee to offer psychiatric support and guidance as psychiatric problems are considered under this program." The House then adopted the report of the Disabled Doctors Program as amended; specifically it adopted recommendation 1, recommendation 2 as amended by the Van de Wetering motion and recommendation 3 as amended by the Reference Committee.

AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Phil C. Astin, Jr., President

"Better Community Health Through Health Education" was the over-all theme of the Auxiliary to the Medical Association of Georgia for 1975-76.

Membership is the lifeblood of any organization. We have an increase in members this year. Three new auxiliaries have been organized with possibly two more before the end of the year.

Health Education has been very much in the front line this year. County auxiliaries have worked with PTAs, school boards, mental health associations, Red Cross, Health Department, and many other local and state groups to educate the communities of the needs of our young people. Your president has been working with the Georgia PTA Health Committee on a three-year health care educational program.

AMA-ERF support has increased this year with 23 auxiliaries having some type of AMA-ERF program.

The Pulse Line has had an outstanding year. Material from 25 auxiliaries was sent to the editor.

Health career days—scholarships—health career clubs have all increased.

Eight county presidents-elect, your state president and president-elect went to Chicago for a Leadership Conference. It has been an honor to have been your President. I am ever grateful for the opportunity to make new friends and renew old friendships. As President, I have visited 34 auxiliaries and 6 new groups. The following list of other meetings and conferences have been attended:

MEETINGS ATTENDED

Planning Meeting Health Careers' Clubs, Georgia Hospital Association
MAG Council Meeting, LaGrange, Georgia
Workshop for State Committee Chairmen
State Rural Health Meeting
AMA—Auxiliary Annual Convention
State Auxiliary Summer Board Meeting
September MAG Council Meeting
AMA Auxiliary Fall Conference—Chicago
MAG Legislation Meeting
Teen Nutrition Meeting
State PTA Comprehensive School and Community Health Education Project Meeting
MAG Annual Scientific Assembly
AMA Annual Scientific Assembly
Southern Medical Association Meeting
Auxiliary Winter Board Meeting
January MAG Council Meeting
Workshop Planning Meeting PTA—Health Education Project
AMA National Leadership Conference—Chicago
AMA—Auxiliary Southern Regional Meeting
Convention Planning Session, Brunswick, Georgia

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee has reviewed the annual report of the Auxiliary to the Medical Association of Georgia and recommends approval of this report with highest commendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Auxiliary.

PRESIDENT

David A. Wells, M.D.

The activities of the Medical Association of Georgia for the past year have been adequately reported elsewhere in the Delegates Handbook. There is no need for me to repeat the details here. I want to commend the officers of the Association for their diligent attention to their responsibilities, especially I want to thank the Councilors and Vice Councilors for their willingness to respond to four called meetings of Council, in addition to the regular meetings. Two of the extra meetings were necessary to work through the Medicaid manual and provider agreement controversy (out of this came the Association's lawsuit against the State). The November called meeting of Council was to repeat the PSRO debate over application for a planning contract. The instructions of the House of Delegates was carried out. The application is in suspension until 15 days prior to the new deadline of January 1978. The March called meeting was to study the budget.

All of the Committees of the Association have done their assigned tasks. The work of several stand out. The Professional Liability Insurance Committee proposed a legislative package and the Legislative Committee did a great job in getting part of it passed by the legislature.

The Education Committee has proposed a program of involvement of the MAG in the Continuing Medical Education field that is outstanding. Read the entire report. This is a big part of the future of MAG.

The first Scientific Assembly was held in November. It was successful beyond expectations. This should be continued and supported.

I feel that the officers, Council, and committees have carried out the directions of the House of Delegates. In many instances new ground had to be plowed. Each person with the responsibility of a vote on these matters did what he thought was right. This is representative democracy at work. If someone is not representing his constituents, they should replace him.

The financial status of our Association must be discussed. The Finance Committee, Reference Committee F, and most of the Executive Committee spent a whole day studying the budget. Requests from each committee chairman for funds were carefully considered. The headquarters office budget was gone over carefully. The finished budget is a large one. The above named group believes that it is a reasonable one. If the Association is to continue its work, the budget must be passed. This will mean that additional income must be secured. The only way is to increase our dues.

Before I leave office as President, I must express my

heartfelt thanks to the staff of the MAG. This group is without equal. Each one has gone above and beyond the guidelines of his or her job to get the work done. Mr. Jim Moffett has done an outstanding job of directing the activities of the Association. Thanks again, friends, for all you have done.

The coming year will be a great one for our Association. Fleming Jolley has been my right hand during this year. I can't thank him enough for his support and guidance. He will be a great President of a great organization.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has reviewed the report of the Office of the President and recommends approval with commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the President.

AMA DELEGATION

J. W. Chambers, M.D., Chairman

The year 1975 was again a busy year for your AMA delegation. It seems that here again there has been an increase in the total volume of information which must be considered by the AMA House of Delegates during each session although the information is well organized and makes it somewhat easier for the House to deal with than in some earlier years. Your Association was well represented at both the Annual and the Clinical Sessions by virtually an entire delegation and each reference Committee was adequately covered in both sessions of the House of Delegates in 1975.

AMA'S FINANCIAL SITUATION

The primary information which I think the MAG House of Delegates would be interested in, as a result of the Annual Session, was that the AMA House finally came to grips with the financial problems and completely supported the Board of Trustees in their attempts to develop some control of the AMA's budgetary problems. You will recall there was an assessment passed by the House in 1974 for the year 1975 and this was quite well supported by the membership. This gave the AMA sufficient working capital in order to solve its money problems for the immediate time being. Upon receipt and consideration of complete reports on the restructuring of the councils and committees of the AMA, a submission of the proposed budgets of every department with reductions wherever possible and the Board going to a zero based budget, giving the Board a great deal more administrative control of the budget, the AMA House passed a dues increase. This increase raises the AMA dues to $250 per year from $110. With this there were considerable administrative changes in the managerial areas of the AMA completed by the Board to more nearly meet the needs of today's AMA. All in all this resulted in a reduction of personnel by somewhere between 50 and 100 which also added to the ability to limit the budget to some degree.

PSRO

At the Annual Session there was a discussion of the 19 amendments which had been reintroduced into the congress that were sponsored and recommended by the

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American Medical Association. These are to be pushed in the 94th Congress in order to try to effectively cope with some of the inequities under the PSRO Law as it has been passed.

AMA PUBLICATIONS

I believe you would also be interested in knowing that the Annual Session also had an opportunity to be brought up to date with a complete review of the publishing business of the American Medical Association. Since that time some of you may have noted that the publication, *Today's Health,* has been sold by the American Medical Association to an outside publisher; the amount of the sale I do not know at the present time. In addition to the sale of the publication, *Today's Health,* there have been some changes made in the *Journal of the AMA.* Various scientific specialty publications which are published and provided by the AMA and as a part of dues will no longer be included free but will be charged, or charged at a reduced rate, so as not to make it a complete deficit item.

FMG'S

During the Annual Session there was also a complete review brought to the House of Delegates on the foreign medical graduate problems and the attempts that are being made to try to resolve some of these problems. This is a complex problem which relates to licensure and the ability of the medical profession in the United States to absorb these foreign medical graduates into the mainstream of American medicine.

MALPRACTICE

There was an in depth report brought to the House during the Annual Session on the malpractice problem as it seemed to be developing and a report from the Board of Trustees as to measures which can be taken which could help to alleviate this problem to some degree. Among these is the formation of a reinsurance company by the American Medical Association and the development of the criteria which is necessary if it is to function successfully.

MEDICARE-MEDICAID REIMBURSEMENT

During the Annual Session of the Georgia House of Delegates, a resolution was passed with a request that it be forwarded to the House of Delegates of the AMA relating to the problem of reimbursement under Medicare and Medicaid and the formulas which are now being used for that reimbursement. These regulations in effect tie these fees to an artificial economic index for which the law and the regulations do not provide. The Georgia resolution was forwarded and given number 59 in the AMA House and was referred to Reference Committee A where it was considered along with report JJ of the Board of Trustees which relates to the same subject matter. Report JJ of the Board is a long and detailed critique of these regulations as they were promulgated and the reason why they are not equitable and reasonable and outlines the proposed action which the Board is taking to try to get these regulations amended or rescinded to a more equitable type of pay-

ment under these regulations. The Reference Committee considered resolution 59 from Georgia along with an additional resolution on the same subject material and came up with a substitute resolution for both resolutions which reads, "Resolved that the AMA reaffirm its long standing position that government programs which pay for physician's services should base their payments on physicians' usual and customary or reasonable charges."

AMA CLINICAL SESSION

As most of the members of this House are aware, the Clinical Session of 1975 was held in the State of Hawaii in Honolulu and had the highest attendance of Medical Association of Georgia membership of any session of the AMA which this writer has ever seen. One might well understand the reason for this, but in spite of the holiday atmosphere and the opportunities for some fun and enjoyment, I must say that the sessions of the AMA House of Delegates were equally as well attended as at any other AMA session of the House that I have ever attended and the business was seriously considered and passed on in businesslike fashion. The Clinical Session covered the usual ground of housekeeping chores for the AMA House with many reports of operations at year end from the various councils of the AMA and the activities of the Board of Trustees as well as a final report on the Budget and a report on the final figures for the payment of the assessment for 1975 to that date. American Medical Association members in the number of approximately 140,000 have paid the 1975 $60 assessment.

LONG RANGE PLANNING AND DEVELOPMENT

A particularly controversial report at the Clinical Session was the report of the long range planning and development committee. This was assigned to the Special Committee F of the House of Delegates. This report was discussed in rather minute detail, many changes were suggested, all of these were considered and the final report was filed to be reintroduced at a subsequent House of Delegates session in order that the long range planning and development council could have ample opportunity to go back over the material and have the advantage of the input from the House of Delegates itself in their report. There were many items in this report which reflect rather major changes in structure and in administration of the AMA and this seemed to be why the House considered this of such marked importance. I believe the House acted in wisdom in what it did and I think ultimately this report will prove to be of considerable value to the American Medical Association and to the entire medical profession in the United States.

AMA LAWSUITS

Finally, Mr. Speaker, the year 1975 saw the American Medical Association take on a more aggressive attitude legally toward some of the inequities which are already being pushed on the profession. As you will recall, two lawsuits already have been filed. One has resulted in the withdrawal of regulations which were totally abhorent to the medical profession. The other is a lawsuit in which a decision has not been rendered which is against the maximum allowable cost regulation which would enable the federal government to require that generic drugs be used rather than drugs being based purely on quality or on the judgement of the prescribing physician. I believe this House would also be interested in knowing that the Board of Trustees of the AMA is seriously considering the possibility of a suit against the National Health and Reorganization Act program. This act was passed in the last one or two days of the 1974 session of Congress and signed into law, setting up the health service areas, etc., which have already become to such a large degree controversial in this state. The legal attack on this legislation might very well be an effective way of combating this type of legislation.

If there are any questions by any members of this House, either I or other members of your AMA delegation will be most happy to attempt to answer your questions or to provide you with materials from the proceedings of the House of Delegates of the AMA for whatever information you may need. Thank you for the opportunity of serving you in this capacity.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee has reviewed the report of the AMA delegation and recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the AMA delegation.

COMMITTEE ON LIAISON WITH THE GEORGIA STATE MEDICAL ASSOCIATION

Mason G. Robertson, M.D.

The Committee as a whole did not meet this year, in fact has never met during its entire existence but has maintained on a formal basis an ongoing relationship with the Georgia State Medical Association. Your Chairman was invited to attend the annual meeting of the Georgia State Medical Association held at Hilton Head Island in the spring of 1975. We did attend and participated in the scientific program.

Until such time as the House of Delegates gives an expanded role to this Committee, we will probably proceed in the same tradition as in previous years.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that this report be received for information.

HOUSE OF DELEGATES ACTION—Received for information.

COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

T. A. Sappington, M.D.

The Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia met on December 14, 1975.

Complaints that had been received by the committee were discussed.

The main purpose of the meeting was that Council of the Medical Association of Georgia has previously endorsed the Disabled Doctors Program for Georgia and had asked this committee to accept responsibility for its activity. This was the second attempt to have a

meeting of this committee this year, and a majority of the members of the committee has responded that they would attend the meeting on the 14th of December, 1975. Only three members of the committee were present, but they felt the plan very worthwhile and agreed that the Professional Conduct and Medical Ethics Committee should accept the responsibility for the activity of the Disabled Doctors Program. Council has been notified of the committee's action. Accepting this responsibility will require at least three meetings of the committee each year. The next committee meeting is scheduled for Sunday, the 28th of March, 1976. It is hoped that the members of the committee will arrange to be present at the next meeting of the committee.

Even though there has been only one official meeting of this committee during the past year, the committee has not been inactive. A fair number of complaints have been received by the Professional Conduct and Medical Ethics Committee and these complaints have been handled by the chairman of the committee and Mr. Sherwood Williams of the staff of the Medical Association of Georgia. It is requested by the committee that Council examine very carefully any complaints referred by component chapters of the Medical Association of Georgia before sending these complaints on to the Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia for this committee to accept this responsibility of trying to investigate and resolve these complaints. This committee has been active during the past year, and will have to be much more active this year.

No request is made at this time for budgeting any funds for this committee.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed the annual report of the Committee on Professional Conduct and Medical Ethics and recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Professional Conduct and Medical Ethics.

Chairman McDowell thanked the members of the Reference Committee for their service and expressed the gratitude of the committee to the House for allowing them to serve on this reference committee.

REPORT OF REFERENCE COMMITTEE B

DANIEL B. STEPHENS, M.D., MARIETTA, *Chairman*

Chairman Stephens reported to the House of Delegates that all the reports and resolutions referred to Reference Committee B had been considered by the committee which met at 2 p.m. in Colony Hall, Holiday Inn, Jekyll Island on Friday, April 9, 1976. Members of the committee included Daniel B. Stephens, M.D., Marietta, Chairman; H. Hilt Hammett, Jr., LaGrange, Vice Chairman; David M. Boyette, M.D., Albany; Lawrence L. Freeman, M.D., Chamblee; Don Schmidt, M.D., Cedartown.

REFERENCE COMMITTEE B

SECRETARY MEMBERSHIP INSURANCE

Earnest C. Atkins, M.D.

RECOMMENDATION

Direct the Insurance Committee to review the AMA programs, compare them to the Southern Medical Association program and acquaint the MAG members and non-members with the advantages of the AMA program. This would require more members to join MAG and AMA to take advantage of these insurance programs.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee received the recommendation of the Secretary dealing with participation in AMA insurance programs. The Committee agrees that the MAG should attempt to improve services available to its members and that one of these ways is in providing an outstanding insurance program.

Therefore, your Reference Committee recommends approval of this portion of the Secretary's Report but moves amendment so that it would now read as follows: "Direct the Insurance Committee to review AMA programs and compare them to the Southern Medical Association's program. Whenever the AMA program is equal or superior, MAG members and non-members should be advised of any advantages of the AMA program. This would encourage more physicians to join MAG and AMA to take advantage of these insurance programs."

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary on Membership Insurance as amended by the reference committee.

COMMITTEE ON MEMBERSHIP INSURANCE

William Perrin Nicolson, III, M.D.

The Committee on Membership Insurance has reviewed coverage which is offered by several other state medical associations, and have found that the Southern Medical Program as offered to our membership is as inclusive as other states excluding, of course, malpractice insurance policy. The rates of the various forms of coverage are certainly competitive though there are a few variations noted in this review.

We will continue to periodically review our insurance program to determine if any additions or deletions are required.

RECOMMENDATION

MAG endorses mailing by Insurance Specialists, Inc. with regard to their disability program, which has been sponsored by the MAG for a number of years, since one of the failings of any group plan is lack of follow-up and the introduction of "new blood" into existing programs.

REFERENCE COMMITTEE RECOMMENDATION —This report recommends that MAG encourages In-

surance Specialists, Inc., to send out an all-member mailing concerning their disability insurance program which at one time had been sponsored by the MAG. The MAG currently endorses the Southern Medical Association's package of insurance programs which includes disability insurance. It should also be noted that the Council in its review of this report recommended disapproval of the recommendation. Because your Reference Committee felt that allowing such a mailing would dilute participation in the Southern Medical Program, which it currently endorses, your Reference Committee recommends that this recommendation be disapproved.

HOUSE OF DELEGATES ACTION—The report of the Committee on Membership Insurance was not approved.

COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D.

The Access to Health Care Committee met January 11, 1976, and began consideration of the report of the questionnaires mailed to the practicing physicians of the State of Georgia and the statistics collated by Mr. John Harrington. The Committee wishes to thank the House of Delegates and the Executive Committee for their support in financing this study which we think will enable us to function in a more meaningful way in the future.

The Committee was appreciative of the fact that such a large percentage of the physicians of Georgia both in primary health care and in specialties chose to answer this questionnaire and give us the necessary information. The Committee noted with interest the fact that urban physicians who possibly predominate in the specialties do not see the primary health care shortage as much of a problem as the physicians who render primary health care in the smaller communities.

The Committee reiterates again the fact that every small community in the State of Georgia does not necessarily perceive its health care needs the same way as the physicians in the adjacent areas, but all are agreed on one point and that is the fact that more persons trained in primary health care are needed in the under-served areas and the smaller communities.

Before any community begins to seek family physicians or other primary health care persons, there should be consideration of the needs of the physician and his family both in terms of housing and situation. Any community that desires to have one or more physicians come to an under-served area should reflect that these young people are in debt for their education, and therefore are not amiable to the idea of going into further debt in order to build a facility. The community should look around and see what health care facilities it has available or should there be consideration of the existing medical centers available within a radius of 20 to 30 miles.

Most young physicians today prefer to practice in a group and with persons nearer their age, and they and their spouses evaluate community needs and also the needs of their families. These include education, recreation, ability to carry on continuing education, coverage when absent, and many other factors.

The Committee believes that there should continue to be a critical evaluation of the use of physician's assistants and/or nurse practitioners. Many physicians for whatever reason feel uncomfortable using extenders, but others have been trained to use these people in a health care capacity or as part of the health care team and feel comfortable in so utilizing them. All should be reminded, however, that under the law a physician's assistant has to work directly under one physician and that that physician's name must be on his certificate; therefore, unless a physician properly trained is located in an under-served community, then there is no way a physician's assistant can be utilized without serious medical, legal, and other problems. The Committee has no pat answers to this problem at this time, but would remind the House of Delegates of the result of the questionnaire and survey.

The Access to Health Care Committee believes that a listing of available physicians should be continued by the Medical Association of Georgia and that this listing be available to communities seeking physicians. It is also believed by this Committee that many towns and counties would profit from the experience in Michigan and other states whereby dialogue was commenced with young medical students while in school and that some effort be made to help interest the prospective physician in these communities even to the point of rendering financial aid while in training.

It is proposed that henceforth the Access to Health Care Committee be the advisory agent to process the requests for primary health care physicians in communities after the points already raised are considered by those places. It is believed that the staff of the Medical Association of Georgia could help in this endeavor by answering correspondence relative to these requests for help and could answer such places and acquaint them with the ground rules. The doctors in the areas adjacent to such a community could be solicited anew or their response to the questionnaire be utilized to see if their appreciation of the needs of this area coincides with all concerned. Thus, the Access to Health Care Committee would act on identified problems somewhat in the manner that the Professional Ethics Committee reacts to such.

Lastly, the Access to Health Care Committee reiterates again the need for support from organized medicine of the training of family physicians and other primary health care people in the State of Georgia and again suggests that the State Assembly and Governor approve line item financial support to the training of such people. This represents a repetition of previous requests, but under the system it is necessary for organized medicine to react through its House of Delegates and in turn notify the State Assembly and Governor of its position and there is a lag time of a number of months.

Considering the fact that the number of medical school graduates is at an all time high, then there is no reason to believe that under-served and rural areas cannot look forward to relief to the problems of the securing of medical help when as and if it is necessary in the next five years.

In conclusion, it should be pointed out that there is no health manpower policy enunciated in Georgia by any agency at this time. We might do well to study the situation in Virginia where this function is carried on by the State Licensing Board.

RECOMMENDATIONS

1. MAG should continue to critically evaluate the use of physician's assistants and nurse practitioners. An existing committee or a new committee should be charged with this task by Council.
2. The listing of communities seeking physicians should be continued by MAG. The Access to Health Care Committee will be available to counsel the communities.
3. The MAG continues to wholeheartedly support the training of family physicians and other primary health care physicians in Georgia and encourages the Governor and legislature to provide state support for their training.
4. In order to develop a health manpower policy statement for Georgia, the Access to Health Care Committee wishes to study the development of such policy in Virginia.

REFERENCE COMMITTEE RECOMMENDATION —The report of this Committee addresses the issues of health manpower, including the availability of primary health physicians in the smaller communities of our state, and the use of physician extenders, such as physician assistants and nurse practitioners. The report also makes reference to the Supplemental Report of the same committee which provides a substantial amount of information based on a study which was done by the MAG Research and Development Department on physician manpower.

Your Reference Committee recommends approval of the following recommendation to be substituted for Recommendation 1: "The MAG Committee on Physician's Assistants should continue to critically evaluate the use of physician's assistants and nurse practitioners." It should be noted that the report of the Committee on PAs was discussed and will be reported on by Reference Committee D.

HOUSE OF DELEGATES ACTION—Adopted the substitute recommendation 1 as offered by the Reference Committee. Adopted recommendations 2, 3 and 4.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D.

INTRODUCTION

The need for accurate and pertinent information concerning Georgia physicians and their practice patterns has long been recognized. Health planning agencies, both local and statewide, have either sponsored or conducted physician surveys during the past five years. These data collection efforts have, for the most part, met the specific data requirements of the sponsoring agencies. However, the need for statewide information about physicians and their practice patterns has gone unmet. To fill this void and to answer questions concerning physician shortages, the Medical Association of Georgia, in the fall of 1974, appropriated funds for a statewide survey of Georgia physicians. The study was conducted by the Research and Development division between September of 1974 and May of 1975.

The following narrative includes a description of the study design, an analysis of the results of the survey, and some conclusions that can be drawn from the study.

REFERENCE COMMITTEE B

METHOD

The activities involved in the planning and implementation of the survey can be broken down into four main categories. They are: the acquiring of a masterfile of all physicians currently residing in Georgia, questionnaire development, questionnaire mailings, and electronic data processing activities.

Preliminary research indicated that several organizations and agencies maintained lists of physicians residing in Georgia. The organizations included the Medical Association of Georgia, the State Office of Comprehensive Health Planning, and the State Medical Licensing Board. The files compiled by these organizations were discounted as viable sources to the survey for the following reasons. The Medical Association's files of physicians included, for the most part, only those physicians who were members of the Association. It was felt that if the survey were confined to members of the Association, the ultimate worth of any data generated by the study might well be questioned. The file maintained by the State Office of Comprehensive Health Planning was acquired from the American Medical Association in 1971. It was felt that its age undermined its usefulness to the survey. Finally, the listing maintained by the State Licensing Board was rejected because it was not readily convertible to computer usage.

At this juncture, the American Medical Association was contacted and asked to extrapolate from its masterfile a list of medical doctors currently residing in Georgia. Although questions have been raised concerning the accuracy of the AMA's masterfile of American physicians, recent studies have determined that the AMA has, for the most part, succeeded in its efforts to identify all physicians residing in the United States. The AMA agreed to furnish a listing of Georgia physicians under two conditions. Those conditions were that the AMA be reimbursed for any costs incurred in compiling the computer tape containing the requested information and, further, that strict guidelines be established to insure that the data they supplied not be haphazardly released. The conditions were agreed to and the computer tape was supplied. In order to insure that all physicians providing care in Georgia were identified, information concerning osteopaths, obtained from the State Medical Licensing Board was later added to the AMA data.

Various committees and individual members of the Medical Association were asked to contribute to the development of the questionnaire used in the survey. Their ideas and comments were added to suggestions offered by staff members of GRMP and the State Office of Comprehensive Health Planning. Extensive research was also undertaken to review surveys conducted by other state medical societies, specialty groups and individual researchers. The purpose of seeking input from a wide range of sources was to insure that the questionnaire be as all-inclusive as possible and that the data collected be pertinent and meet the varied needs of diverse groups. Work on the questionnaire was completed (See Attachment A) in December.

The main question which arose during the process

of planning the mailing of the questionnaire was what selection criteria, if any, should be used to determine what physicians should receive questionnaires. The AMA had categorized physicians by the following types of practices:

A. Hospital training
B. Intern
C. Resident
D. Fellow
E. Direct Patient Care
F. Administration
G. Medical Teaching
H. Medical Research
I. Other Patient Care
J. Other Non-Patient Care
K. Inactive
L. Retired
M. Semi-Retired
N. Disabled
O. Temporarily Not in Practice
P. Not Active for other reasons
Q. No Classification

Although the thrust of the study was directed toward physicians in direct patient care and other patient care types of practices, a decision was made to include, in the first mailing, all physicians residing in Georgia. This was done so that an analysis of the rate of change in practice type could be performed later.

Two mailings were conducted, the first in January and the second in February. The second mailing was confined to physicians in direct patient care and other patient care types of practices who had not responded to the first mailing.

Electronic data processing activities extended throughout the survey. Initial work centered upon efforts to make the computer tape supplied by the AMA compatible with the computer system used by MAG. During the development of the questionnaire, a special effort was made to insure that the responses to the questions could be entered into the computer with minimal effort. When completed questionnaires were returned, EDP activities were concentrated on entering data into the computer. When all the data had been entered, data analysis activities were begun.

RESULTS

Response: Of Georgia's 6,369 physicians, 3,520 or 55.5 per cent responded to the survey. Of the 4,203 physicians serving in direct patient care capacities, 2,729 or 64.9 per cent returned completed questionnaires.

Analysis of Response: Preliminary analysis efforts were devoted to determining if any identifiable groups of physicians had not participated in the study. The variable groupings examined were sex, age, specialty and county of practice.

An analysis of responses by sex indicated that on a percentage basis, fewer female physicians returned completed questionnaires than male physicians. This difference in response rate, when tested by Chi Square at .5 was significant. However, because less than 5 per cent of all Georgia physicians are female, this lack of response had little if any effect on the usability of the data generated by the survey.

Examining returned questionnaires by age indicated that in each age grouping, with three exceptions, the survey received majority responses. It is of passing interest to note that the three exceptions occurred at each end of the age spectrum.

A majority of physicians in most medical specialties returned completed questionnaires. Additionally, the response rate in many specialties ran well over 60 percent.

Of Georgia's 159 counties, only 14 failed to have a majority of the physicians in the county return completed questionnaires. All 14 counties are rural and only two (Baldwin and Chattahoochee) have more than 25 physicians practicing in the county.

In summary the analysis of responses indicated that all substantive variable groupings were well represented in the study.

PRACTICE PATTERNS

As discussed in the introduction, this study was undertaken to assess practice patterns of Georgia's physicians and to provide tentative answers to questions concerning physicians shortages. In order to facilitate an understanding of the information generated by the survey, data analysis efforts relating to practice patterns will be discussed first, to be followed by a presentation of the data relating to physician shortages.

The recruitment efforts of communities currently attempting to attract physicians should be designed on the basis of the community's needs versus data regarding current physician practice patterns. It is reasonable to assume that this process of allowing communities to contrast their needs with current practice patterns will increase the likelihood of attracting and retaining physicians. To facilitate that process five aspects of practice patterns were examined. Those aspects are: 1) mode of practice by specialty; 2) mode of practice by primary care physicians; 3) percentage of time spent in office by specialty; 4) percentage of time spent in primary care by specialty; and 5) average number of outpatient visits by specialty.

The majority of Georgia physicians, regardless of specialty, practice in either solo or partnership modalities. The large number of specialists practicing in solo settings apparently contradicts the general assumption that specialists prefer single or multi-specialty groups. As can be seen, few Georgia physicians practice in those settings.

It is of interest to note that with the single exception of general practitioners, the practice settings of primary care physicians (which comprises internal medicine, general and family practice, pediatrics, and obstetrics) do not differ from specialty physicians.

When the practice modes of primary care physicians are examined separately, it can be seen that solo and partnership settings are clear favorites. A closer examination reveals that only 21 percent of primary care physicians practice in other settings. The large number of primary care physicians in solo practice (1,249 or 45.5 percent) dispels the belief that solo practice is a thing of the past. This information should encourage those Georgia communities attempting to recruit physicians for rural solo practices.

The answer to the question of where physicians spend their practice time is important to communities attempting to attract physicians. The data generated by the survey indicates that primary care physicians spend the majority of their practice time in an office

setting. As could be expected, surgical specialists spend less time in office settings than non-surgical specialists. This data would tend to indicate that communities attempting to recruit primary care physicians should stress either availability of medical office space or the communities' willingness to construct an appropriate facility.

The percentage of practice time spent by specialists providing primary care services has long been questioned. Most specialists who responded to the survey indicated that they spent very little time in providing primary care. This would tend to indicate that specialists cannot generally be viewed as a source of primary care services. Additionally, communities with a defined need for primary care services should not expect this need to be met by specialists.

As could be anticipated, primary care physicians tend to see more patients on a daily basis than other physicians. Surgical specialists tend to treat less than 20 patients a day. Medical specialists other than primary care specialists also average less than 20 patients daily.

The practice patterns of primary care physicians, as has been discussed, tend to differ substantially from physicians in other medical and surgical specialties. Communities which are attempting to recruit physicians should be strongly encouraged to closely examine their needs before efforts to attract physicians are begun. By examining their needs, communities will be more likely to retain physicians attracted by recruitment efforts.

SHORTAGES OF PHYSICIANS

The problems associated with identifying specific geographical areas which need physician services are complex. Consequently, the results of the survey have not been analyzed with the intent of identifying specific Georgia communities in need of physicians. Rather, data analysis efforts regarding physician shortages have concentrated on the development of preliminary information relating to (a) average waiting time to procure a non-emergency appointment with a physician, (b) the use of physician's assistants, and (c) physicians' perceptions of the need for additional physicians.

One of the primary indications of a shortage of medical services is queue time, i.e., how long one must wait to see a physician. The majority of primary care physicians indicated that non-emergency cases can or are seen within seven days. As could be expected, waiting time for an appointment with a specialists takes longer and varies from specialty to specialty. Waiting time does not differ when examined by mode of practice. A patient is as likely to wait for an appointment to see a physician in solo practice as he is to see a physician who practices in a multi-specialty group.

The use of the physician's assistant to alleviate the shortage of medical manpower in under-served areas has been the subject of much discussion. The effectiveness of the PA however is predicated upon the willingness of physicians to both train and employ them. When the data relating to PAs was examined, it was found that the majority of Georgia physicians who spend more than 50 percent of their practice time in primary care indicated that they were not presently interested in hiring a physician's assistant. However, physicians who spend less than 50 percent of their practice time providing primary care were more willing to hire a PA. Since the initial concept of the PA envisioned the primary care physicians rather than the specialist as the principal source of employment, some re-thinking of the concept would seem to be called for. When the data was examined from a rural-urban perspective it was found that urban physicians were more willing to hire a PA than their rural counterparts. Again, the data runs counter to one of the original concepts—that of physician assistants working primarily in rural areas. When the willingness to hire a PA was examined by physicians' age it was found that older physicians were much more likely to oppose the hiring of a PA.

When data relating to physicians' willingness to help train PAs was examined, a relationship was found between a willingness to hire and a willingness to train. Physicians who would hire PAs also voiced an interest in training them. This relationship also held true when examined on an urban-rural and age basis. Although many physicians indicated a willingness to hire a physician's assistant, only 157 have done so. In conclusion, it can be said that Georgia physicians have, at this time, not expressed a great willingness to employ physician's assistants. As a result, the PA cannot yet be viewed as the obvious remedy to medical manpower shortages. This situation would, of course, change if Georgia physicians change their attitudes towards the use of the physician's assistant.

When asked if more physicians were needed in their practice area, 74.8 percent of rural physicians responded affirmatively. Only 44.4 percent of urban physicians saw a need for more physicians. This difference of opinion is, in part, attributable to the tendency of rural physicians to average more out-patient visits than urban physicians. Physicians who indicated that more physicians are needed tended to feel that the additional physician should practice a primary care specialty. It is of interest to note that primary care physicians agreed with the conclusion that additional primary care physicians are in demand.

CONCLUSION

The activities involved in this survey have generated some data to answer questions relating to physicians attitudes, opinions, and practice patterns. The need to gather this information on a regular basis is still unmet. To fill this void, consideration should be given to emulating Virginia's policy of charging the State Medical Licensing Board with the responsibility of collecting and disseminating information concerning physicians. Until steps are taken in this direction, effective planning concerning the needs of and for physicians will remain haphazard and inaccurate.

Data generated by the activities of this survey is available to concerned groups and individuals. Guidelines to gain access to the information can be obtained by contacting the Research and Development division of the Medical Association of Georgia.

REFERENCE COMMITTEE B

OFFICE OF THE PRESIDENT

Dear Doctor:

The MAG House of Delegates expressed a desire

that a comprehensive physician manpower study be conducted in Georgia. As an initial step toward that end, staff has developed the following questionnaire which is being mailed to all Georgia physicians.

This questionnaire is an attempt to determine if a shortage or maldistribution of physicians exists, and may enable MAG to dispel existing misconceptions concerning physician manpower in Georgia. Please take the four to five minutes necessary to complete this questionnaire and return it to us in the attached envelope. Your reply is essential in order for our data to be useful.

Sincerely yours,
J. Rhodes Haverty, M.D.
President
Medical Association of Georgia

1. Where did you do your internship?
   a. City .....
   b. State .....
   c. Affiliated with medical school? Yes .... No ....
2. Where did you complete your residency?
   a. City .....
   b. State .....
   c. Affiliated with medical school? Yes .... No ....
3. Please indicate your *primary* type of practice.
   a. Intern .....
   b. Resident .....
   c. Direct Patient Care .....
   d. Administration .....
   e. Medical Teaching .....
   f. Medical Research .....
   g. Other Patient Care .....
   h. Other Non-Patient Care .....
   i. Temporarily Not in Practice .....
   j. Not Active .....

DEFINITIONS:

a. *Direct Patient Care*—Physicians engaged in seeing patients—also includes patient services provided by pathologists and radiologists, etc.

b. *Other Patient Care*—Physicians rendering patient care as part of other professional activities (other than training, teaching, or research) in hospitals, health facilities, other allied health organizations, or in various health programs.

c. *Other Non-Patient Care*—Physicians engaged in journalism, law, sales, insurance, or other health related activities.

d. *Temporarily Not in Practice*—Physicians presently not engaged in practice but who plan to return to practice within the next six months.

e. *Not Active*—Physicians who are (1) retired, or (2) permanently disabled, or (3) not active for other reasons with no plans to resume practice in the next six months.

4. How long have you practiced in the county of your present location? .....
5. If you have moved your practice (from another county) in the past year, where did you move from?
   a. City .....
   b. State .....
   c. County .....
6. How much of your practice involves the delivery of primary care? ..... %
7. Please check the appropriate box:

A. Weekly time in practice and related functions: under 40 hours . .; 40-50 . .; 50-60 . .; 60-70 . .; 70-80 . .; over 80 hours . .

B. Average number of daily out-patient visits: under 20 . .; 21-30 . .; 31-40 . .; 41-50 . .; 51-60 . .; over 60 . .

C. Average number of hospitalized patients, daily: under 5 . .; 6-10 . .; 11-15 . .; 16-20 . .; 21-25 . .; over 25 . .

D. Age groups comprising 20 percent or more of practice: birth to 5 . .; 6-15 . .; 16-20 . .; 26-50 . .; 51-65 . .; over 65 . .

E. Division of professional time in percent:
Office or clinic: under 20% . .; 20-30% . .; 30-40% . .; 40-50% . .; 50-60% . .; 60-70% . .; 70-80% . .; over 80% . .
Hospital: under 20% . .; 20-30% . .; 30-40% . .; 40-50% . .; 50-60% . .; 60-70% . .; 70-80% . .; over 80% . .

The following table can be completed by your office manager if you so desire. If you are a member of a partnership or a group practice, please insure that the table is completed only once for your practice.

	Total # of Full-Time Personnel	*Total # of Part-Time Personnel*	*Total # of Personnel Who Have Graduated From an Accredited Program*	*Total # of Personnel With On the Job Training*
Physicians Assistant				
Registered Nurse				
Nurse Practitioner				
Licensed Practical Nurse				
Nursing Assistant				
Medical Technologist				
Laboratory Assistant				
Medical Assistant				
X-ray Technician				
Secretary (include typists and medical secretaries)				
Other (specify)				

Other: under 20% . .; 20-30% . .; 30-40% . .; 40-50% . .; 50-60% . .; 60-70% . .; 70-80% . .; over 80% . . .

F. Type of practice: solo practice . .; partnership . .; single specialty group . .; multi-specialty group . . .

8. In your opinion are more physicians needed in your practice area? Yes . . . . . No . . . . .
9. If so, please indicate specialty required. List by priority of need, greatest need first.
10. If you are listed with the AMA as having more than one specialty, what is the approximate percentage of time devoted to each?
11. If you are listed with the AMA as having a specialty and subspecialty, what is the approximate percentage of time devoted to each?
12. Would you hire a graduate of an AMA recognized physician's assistant program? Yes . . . . . No . . . . .
13. Would you allow a physician's assistant to complete his clinical training in your office? Yes . . . . . No . . . . .
14. What is the average waiting time for non-emergency appointments? . . . . . .
15. Are you currently accepting new patients? Yes . . . No . . . . .
16. Do the resources available for continuing medical education in your community meet your needs? Yes . . . . . No . . . . .
17. Has a lack of coverage for your practice been a consistent deterrent to your participation in continuing medical education activities? Yes . . . . . No . . . . .

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee commends the Committee on Access to Health Care for its excellent work in preparing and reporting the information collected in this study. Your Committee recommends acceptance of this report for information.

HOUSE OF DELEGATES ACTION—Received for information.

SUPPLEMENTAL REPORT OF THE SUBCOMMITTEE ON RURAL HEALTH

Irving D. Hellenga, M.D.

WHEREAS, physicians are in urgent need in rural areas, and

WHEREAS, rural physicians are called upon to perform a greater percentage of health care provided in Georgia, and

WHEREAS, various government and third party payors now practice geographic discrimination in establishing fee schedules that pay rural M.D.s less than urban M.D.s, and

WHEREAS, more M.D.s would locate their practices in rural areas of need if this discrimination were eliminated, now

THEREFORE, the MAG Rural Health Subcommittee calls upon the MAG to petition AMA, and our congressmen and senators to rectify this discrimination, and

FURTHERMORE, that financial incentive be provided by equalizing fees regardless of geographic or population criteria.

REFERENCE COMMITTEE RECOMMENDATION —Although your Reference Committee heard arguments on both sides of the issue of payment differentials based on geographic regions, the predominance of opinions expressed seemed to support the concept that equal service deserved equal pay. Your Committee agrees that it certainly is no longer valid to assume that the costs of medical practice are less in rural than in urban areas. Furthermore, your Committee supports the concept that fees should be based on services rendered and not on the location at which they are provided.

Mr. Speaker, your Reference Committee recommends the adoption of this resolution with the amendment of the second Resolved by inserting the words "regardless of geographic or population criteria," after the words "equalizing fees," and deleting the remainder of the Resolved. Thus, the second Resolved would read "Furthermore, that financial incentives be provided by equalizing fees regardless of geographic or population criteria."

HOUSE OF DELEGATES ACTION—Adopted the report of the Rural Health Subcommittee with an amended second resolve that reads "Furthermore, that financial incentives be provided by equalizing fees regardless of geographic or population criteria."

REFERENCE COMMITTEE B

COMMITTEE ON MEDICAL PRACTICE

W. Dan Jordan, M.D.

Your Committee on Medical Practice has been busy with several new and important issues as well as some old problems like certificate of need and fiscal audit. The issue of fiscal audit is addressed in a separate supplemental report of the committee. The comments that follow summarize the business of the committee over the past year.

CERTIFICATE OF NEED

Discussed the requirements of the HSA law regarding certificate of need legislation and concluded that in the event a certificate of need law is passed by the Georgia legislature, it should contain the following three alternatives:

1. The application should be accepted by the planning agency on its merits as detailed by the local group.
2. Assuming that all facets are equal and reasonable, the regional authority should accept the plans of the applicant and give conditional approval to these plans. The applicant would have a certain amount of time in which to demonstrate the feasibility and necessity of the facility or service. Approval could be withdrawn if the facility did not prove itself.
3. The plan should be rejected on the basis that it is not feasible or is unnecessary.

NURSING HOME MEDICAL DIRECTORS

Agreed to close liaison with the Association of Nursing Home Directors. Also, opposed the closure of nursing home staff to the attending physician in favor of retaining the freedom of the patient to choose his own physician.



Heading the receiving line (L) during the Saturday evening President's Reception at the Annual Session are Dr. and Mrs. David A. Wells of Dalton, and Dr. Jolley.



Representing the Auxiliary at the reception are (L) Mrs. Milton F. Bryant of Atlanta, incoming president, and Mrs. Phil C. Astin of Carrollton, outgoing president, and their husbands.

CLOSED HOSPITAL MEDICAL STAFF

The Committee recommends that MAG Council make a basic legal study of contractural relationships between physicians and hospitals.

The Committee adopted the following statement regarding contractural relationships between physicians and hospitals.

All contracts concerning the delivery of medical services in a hospital should:

1. Recognize the freedom and right of the patient to choose his doctor and the right of the doctor to choose his patient (emergency situations excepted) and that,
2. The establishment of contractural relationships between any physician group of physicians and a hospital should be subject to approval by the medical staff, and that,
3. All persons who are included in a contract are to be members of the medical staff. Note: Individuals that are not, for any reason, acceptable to be members of the medical staff could not join in a contract with the hospital.

AMA'S REQUEST FOR COMMENTS ON JCAH MANUAL FOR HOSPITAL MEDICAL STAFF

Reviewed and made recommendations to Executive Committee for a number of changes in the standards. These changes included:

1. Suggesting that imperative verbs be changed to more flexible phraseology;
2. Dropping the mandatory requirement for a physician to sign a statement attesting to the reading of and the abiding by hospital bylaws;
3. Dropping the mandatory language on proximity of physical location by physician to hospital;
4. Revise temporary privileges language suggesting dual admission, supervision and/or other measures to be in effect for physician's extended privileges;
5. Change the mandatory requirements for continuing education to the encouragement of both formal and informal continuing education programs.

THE GEORGIA COMPREHENSIVE HEALTH PLAN

Reviewed the Georgia CHP and recommended to Executive Committee that:

1. MAG disagree with the philosophical basis for the plan;
2. The plan is unrealistic;
3. The plan lacks private practicing physician input;
4. The plan is unacceptable in its present form;
5. MAG is willing to work with the State to develop a realistic plan in terms of goals and delivery mechanisms.

FISCAL AUDIT RESOLUTION

Revised resolution referred by 1975 House of Delegates. Recommended opposition to use of prospectively determined criteria lists used by reviewing organizations in making a final decision. (See Annual Report —Resolution 9-75.)

AMERICAN HOSPITAL ASSOCIATION REPORT ON AMBULATORY CARE

Suggested major changes and presented several criticisms of AHA statement on hospitals' roles in providing health care on out-patient basis.

NON-CONDUCTIVE HOSPITAL FLOORING

Supported recommendation of Emory University's Department of Anesthesiology to Department of Human Resources that licensure regulations be changed to allow use of non-conductive flooring.

The Medical Practice Committee continues to maintain interest in issues involving the delivery of medical care and stands ready to contribute its opinions to the development of policies on this question by the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION

—Your Reference Committee was impressed with the range of activities of the Committee on Medical Practice and the diligence with which they have applied themselves to the charge of this committee. Mr. Chairman, your Reference Committee recommends acceptance of this report for information only.

HOUSE OF DELEGATES ACTION—The Reference Committee recommendation was amended on the floor to refer that portion of the Committee on Medical Practice Report coming under the headline "CLOSED HOSPITAL MEDICAL STAFF" to Council for study and assessment. All other portions of the report were received for information.

COMMITTEE ON MEDICAL PRACTICE RESOLUTION 9-75

W. Daniel Jordan, M.D.

As many of the delegates will recall, last year the House referred Resolution 9-75 Fiscal Audit to the Committee on Private Practice for further consideration and clarification. The Committee on Medical Practice has met on several occasions to consider the Fiscal Audit Resolution, and after considerable discussion, recommends to the 1976 House of Delegates adoption of the following Resolution:

WHEREAS, prospectively determined clinical criteria lists are being distributed by the American Medical Association, the Joint Commission on Accreditation of Hospitals, PSROs, Third Parties and various other groups; and

WHEREAS, the concept of medical necessity, being defined as the decision concerning the need for continuing hospitalization, has been accepted and these decisions being rendered by functioning groups within hospital medical staffs; and

WHEREAS, the concept of quality audit, being defined as the retrospective evaluation of medical care delivery, has been endorsed and encouraged by the Medical Association of Georgia; therefore be it

RESOLVED, that the Medical Association of Georgia recommends that prospectively determined clinical criteria lists should never be used by payors, review committees of hospitals, or peer review activities of medical societies in determining coverage by third parties; but they can be used for screening purposes as long as final decisions are based solely on the facts of the individual case in relation to sound medical practice as judged by the peers of the physician who provided the care.

REFERENCE COMMITTEE RECOMMENDATION —As many Delegates will recall, this resolution was brought before the House of Delegates in 1975. At that time, it was referred for additional study to the Committee on Medical Practice. The Medical Practice Committee now recommends adoption of its revised resolution. The resolution urges that clinical criteria lists not be used in final decisions made by third party payors, hospital review committees, or others in determining coverage by third parties. The committee recommends that each case be reviewed individually by the peers of the physician who provided the care.

Your Reference Committee agrees wholeheartedly with this concept and recommends adoption of the report on revised Resolution 9-75.

REFERENCE COMMITTEE B

HOUSE OF DELEGATES ACTION—Adopted Resolution 9-75 of the Committee on Medical Practice.

GEORGIA MEDICAL CARE FOUNDATION

Earnest C. Atkins, M.D., President

After five years of operation, the Georgia Medical Care Foundation has begun to broaden its areas of involvement in the medical community, moving from a punitive to a constructive force. Several specific items of interest merit your attention.

Efforts to implement the CHEC Program for use for all Medicaid patients were unsuccessful due to a conflict of interpretation of the requirements of utilization review regulations between the Foundation and Medicaid administration. At the time that the State terminated its involvement with the CHEC Program, well over half of the hospitals in the State of Georgia were in various stages of implementation and operation of the CHEC Program. I have addressed this problem in more detail in the pages of the *Journal of the Medical Association of Georgia* from time to time this past year, and while this represents a set-back in our schedule, our efforts in this area will continue.

The remainder of our contract with the State for review of Medicaid claims is complete and work is progressing smoothly. The Nursing Home Review Program has been significantly increased in scope and size this year with the Foundation being totally responsible for all utilization review, and other types of review, conducted in each of the over 300 nursing homes in the State of Georgia this year. Between the nursing home program, the specialty panels, and the private practicing consultants working with us, over 500 doctors in the state are actively involved in the workings of the Foundation.

A new undertaking for the Foundation this year was to conduct an intensive and in-depth institutional self-evaluation. The evaluation was overseen for the Board of Directors by John R. McCain, M.D., Atlanta and its purpose was to step back and take an objective look at ourselves and see whether there are things that we can do to improve our functioning, our services and our relationship with the physicians and patients in the State of Georgia. This self-evaluation is to be followed by an outside evaluation by national experts on foundations for medical care sometime in the middle of 1976.

Because of our deep involvement with the Medicaid and Medicare Program as review agents, there has been considerable opportunity for the Foundation to examine and consider the structure of the health administrative system in the State of Georgia. In the midst of all the cries on Capitol Hill for restructuring of the health care delivery system, we felt that there might be some value in first examining exactly what kind of a system we have at this time and considering less radical changes that might effect better service to the patients and physicians utilizing the components that we already have in place. To this end, the Board of Directors of the Foundation has constituted a Study Commission to examine this question, and at the date of the writing of this report, we are still waiting to see whether funds for the study are forthcoming from the

federal government. I will be happy to give you an update on the status of this Commission during the reference committee meeting.

Finally, I come to an area of endeavor in which we have expanded our activities this year in conjunction with the Medical Association of Georgia, an area that is difficult to discuss but also necessary. This is the matter of organized medicine's review and sanction of physicians in Georgia whose practice is counter to our goals of excellence in patient care. In other words, the self-policing of the medical community. During the past year, mechanisms and pathways have been established for referral of those few physicians whom we identify as consistently practicing in a standard of medicine with which the majority of the medical community does not agree, to the Council and Executive Committee of the Medical Association of Georgia for appropriate follow-up and further action, and I must report that these mechanisms and pathways have been utilized during this past year. If the private practice of medicine is to continue, we must keep our own house in order, and the ability to do this now exists.

REFERENCE COMMITTEE RECOMMENDATION —The Annual Report of the Georgia Medical Care Foundation describes and summarizes the activities being engaged in by the State Foundation. Of special interest is the recent self-evaluation which is to be followed up by an outside evaluation by national experts some time this year.

Mr. Speaker, your Reference Committee recommends acceptance of the Foundation report for information and offers the highest commendation to its president, Earnest C. Atkins, M.D., and the Board of Directors of the Georgia Medical Care Foundation for their continuing excellent work on behalf of all Georgia physicians.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Care Foundation.

SUPPLEMENTAL REPORT OF COUNCIL PSRO

Fleming L. Jolley, M.D., Chairman

At a Special Meeting of Council held November 9, 1975, to discuss the ethics of MAG's participating in formation of a PSRO, a motion was made (Jordan/Johnson) that Council, noting the conflicting actions of the 1974 and 1975 House of Delegates, direct staff to cease any effort to apply for a planning contract on PSRO until the House of Delegates has an opportunity to resolve these conflicting positions at its next meeting. This motion was tabled until the next (1976) Annual Session of the House of Delegates.

This Special Meeting of Council was called at the request of eight councilors supporting a petition of the Bibb County Medical Society. Their petition raised the question of how the 1975 House of Delegates would direct MAG participation in PSRO when the 1974 House of Delegates has adopted a report which noted that participation in PSRO would be unethical.

MAG legal counsel advised that the House of Delegates could take an action overriding previous House of Delegates action without specifically repealing that previous action. In his letter of November 3, 1975, to Fleming Jolley, M.D., Chairman of Council, Mr. Huff stated,

> The House of Delegates possesses plenary power. It has the authority to determine an issue one way at one time and reverse itself at a later date. There is, in my view, no requirement that its decisions necessarily be consistent or that earlier pronouncements be specifically repealed when the House later decides the same question in a different way. . . .

He added that since Council had the powers of the House of Delegates between its sessions, it could act to change the 1975 House of Delegates action.

Subsequent motions to alter the MAG House of Delegates action were defeated. The purpose of this report is to advise the House of the motion which was tabled to this meeting.

REFERENCE COMMITTEE RECOMMENDATION —This report deals again with what seems to have become a perennial issue at the MAG House of Delegates, i.e., PSRO. The report describes a question raised at a Council meeting concerning whether or not it was ethical for MAG to participate in PSRO. Mr. Chairman, your Reference Committee strongly supports the action of the 1975 House of Delegates which directed MAG to apply for a planning contract 15 days prior to the expiration date for preferential treatment to be given to physician groups. Therefore, we accept and support the position taken by the MAG Council and concur with the MAG legal counsel's opinion. We are in agreement with the past actions of Council taken on submission of the PSRO application and its subsequent suspension and recommend that the 1976 House of Delegates endorse this action.

HOUSE OF DELEGATES ACTION—Adopted the report of Council and the Reference Committee's recommendation to endorse the actions of Council related to submission and subsequent suspension of the PSRO application.

RESOLUTION 1-76 COCAINE SUPPLY

William E. Huger, Jr., M.D., for Medical Association of Atlanta

WHEREAS the Medical Association of Atlanta, upon the advice of the Greater Atlanta Otolaryngology Society, recognizes the unique nature and medical necessity of cocaine, and

WHEREAS we feel there is no substitute for the drug and its availability to the Otolaryngological profession for medical uses must be continued, now therefore

BE IT RESOLVED that the Medical Association of Georgia urges the American Medical Association to investigate any arbitrary limiting of the supply of this necessary drug by manufacturers and suppliers.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee heard several members speak in support of this resolution. There was agreement among the specialists testifying that there exists no substitute for cocaine with equivalent vasoconstrictor and topical anesthetic properties. Your Reference Committee recommends adoption of this resolution with amendment, deleting the words "any arbitrary" and substituting for them the words "the reasons for."

Thus, the resolve as amended would read, "the Medical Association of Georgia urges the American Medical Association to investigate the reason for limiting a supply of this necessary drug by the manufacturers and suppliers."

HOUSE OF DELEGATES ACTION—Adopted resolution 1-76 with an amendment to the resolved portion that deletes the words "any arbitrary" and substitutes in lieu thereof the words "the reasons for."

RESOLUTION 2-76
STATE HEALTH COORDINATING COUNCIL (SHCC)

L. Newton Turk, III, M.D.,
for Medical Association of Atlanta

WHEREAS, many county medical societies in Georgia have been interested and involved in the development of health service agencies (HSAs) during the past year, and

WHEREAS, there is a provision in the law for development of a state agency and a "state health coordinating council" (SHCC) at the state level, and

WHEREAS, many county medical societies have realized the importance of the development of these local agencies and the state agency in accordance with Public Law 93-641, therefore be it

RESOLVED, that the Medical Association of Georgia adopt as one of its highest priority projects an interest in and involvement in the development of the state agency and the state health coordinating council as soon as the regulations for this Council have been written and on an ongoing basis.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee concurs with the sentiment expressed in this resolution that the MAG should take a very active role at the state level of HSA development and operation. However, it should be noted that this should not imply any actual or tacit endorsement of Public Law 93-641. In addition, it was the opinion of your committee that even though the MAG is supportive of the AMA's potential suit against this law, we should act at this time to take an active role in the development of the state health coordinating council.

Therefore, your Reference Committee recommends adoption of this resolution with deletion of the word "highest" preceding the words "priority project" in the resolved portion of the resolution and the amended resolution would then read: "Resolved, that the Medical Association of Georgia adopt as one of its priority projects an interest and involvement in the development of the state agency and the state health coordinating council, as soon as the regulations for this Council have been written, and on an ongoing basis."

HOUSE OF DELEGATES ACTION—Adopted Resolution 2-76 with an amendment that deletes the word "highest" in the resolved portion of the resolution.

SUPPLEMENTAL REPORT OF COUNCIL PEER REVIEW MECHANISMS

Fleming L. Jolley, M.D., Chairman

In meeting on April 8, Council voted to send the following resolution to the House of Delegates with a recommendation that it be adopted in lieu of Resolution 5:

WHEREAS there exists in Georgia a functional and comprehensive peer review mechanism within organized medicine, and

WHEREAS significant numbers of health insurance carriers and intermediaries doing business in Georgia utilize medical review systems outside of organized medicine and frequently outside of the State of Georgia, and

WHEREAS the practicing physicians of Georgia are willing and able to perform such review for the sole purpose of assuring the delivery of the highest quality medical care to the citizens of Georgia consistent with the needs of the patient and the resources of the physician and the community in which he practices,

NOW THEREFORE, BE IT RESOLVED that the Medical Association of Georgia endorses and supports only that medical peer review performed by practicing physicians free to exercise their independent professional judgment at the time of the review and conducted within the established and recognized peer review system constituted by the Georgia Medical Care Foundation and the Metropolitan Atlanta Foundation for Medical Care, and

BE IT FURTHER RESOLVED that all carriers and intermediaries doing health insurance business in the State of Georgia be informed of this resolution and urged to conform with its intent and direction, and

BE IT FURTHER RESOLVED that progress in this area be periodically monitored to determine the need for further action on this matter.

REFERENCE COMMITTEE RECOMMENDATION —This resolution was referred from Council to be considered with the resolution which is discussed below, Resolution 5-76. The purpose of this resolution is to encourage third party payors to utilize the functioning peer review mechanisms of organized medicine in Georgia. It should be noted that the author of Resolution 5-76 supported adoption of this resolution in lieu of his own. An issue which was presented to your Reference Committee dealt with the problem of the use of employed physicians by certain insurance companies to review claims. It was felt that such physicians were not true peers, and therefore not qualified to perform review on care provided by private practicing physicians.

Mr. Speaker, Your Reference Committee recommends adoption of this resolution with amendment by inserting the word "private" before the words "practicing physicians" in the first Resolved.

HOUSE OF DELEGATES ACTION—Adopted the report of Council with an amendment to insert the word "private" before the word "practicing physicians" in the first resolve.

RESOLUTION 5-76
UTILIZE PEER REVIEW MECHANISMS

Charles E. Todd, M.D.,
for Medical Association of Atlanta

WHEREAS, two organized functioning peer review

REFERENCE COMMITTEE B

mechanisms exist in Georgia, the Metro Atlanta Foundation for Medical Care and the Georgia Medical Care Foundation, and

WHEREAS, Prudential, Medicare—Part B and various other carriers, presently utilize a review system outside of organized medicine, therefore be it,

RESOLVED, that physicians be reviewed only by other physicians who are free to exercise independent judgment at the time they are conducting peer review, and be it further

RESOLVED, that the Medical Association of Georgia urge the Prudential, Medicare—Part B and other carriers to utilize these existing peer review mechanisms.

REFERENCE COMMITTEE RECOMMENDATION —Mr Speaker, your Reference Committee recommends that this resolution be not adopted as explained earlier in our discussion of the Council report on peer review mechanisms.

HOUSE OF DELEGATES ACTION—Voted to not approve Resolution 5-76.

RESOLUTION 6-76
COST ACCOUNTABILITY COMMITTEE

Harrison L. Rogers, Jr., M.D.,
for Medical Association of Atlanta

WHEREAS, the cost of health care is a major concern to our patients as well as to their third party payors; and

WHEREAS, rising health care costs are of concern to both state and federal governments, and are undoubtedly responsible for much of the regulatory legislation in the health field today; and

WHEREAS, much of the impetus for the passage of National Health Insurance stems from the continued rise in health care costs, and

WHEREAS, physicians direct the expenditure of a large part of the "health care dollar" by virtue of the various needs of their patients (i.e., inpatient or outpatient care, expensive vs. inexpensive diagnostic and therapeutic techniques, etc.); and

WHEREAS, organized medicine at all levels (county, state and national) has actively participated in reducing inpatient health care costs, without reducing quality of care, by means of peer review mechanisms and other physician education programs. Therefore, be it

RESOLVED, that the Medical Association of Georgia:

1. Appoint a special "cost accountability" committee to study the problem and work the component societies and the Georgia Hospital Association in facing this problem.
2. Call on its constituent societies to support this effort by appointing special "cost accountability" committees or by specifically charging an existing committee with this responsibility.
3. Submit a similar resolution to AMA for its consideration.
4. Urge that each hospital staff designate a specific committee as the "cost accountability" committee in each hospital.

REFERENCE COMMITTEE RECOMMENDATION —This resolution deals with the concern of various sectors in our society with the rising cost of health care. It suggests that since the physician directs the expenditure of much of the health care dollar, that organized medicine as his representative should establish committees which would be concerned with cost accountability.

Upon hearing the remarks of the author of the resolution as well as remarks of others, your Reference Committee concurs that, since this is such an important issue with the public and with government, the involvement of organized medicine in this question is also required. More importantly if, indeed, such committees are successful in their tasks, a great benefit would accrue to our patients.

Mr. Speaker, your Reference Committee recommends adoption of Resolution 6-76.

HOUSE OF DELEGATES ACTION—Adopted resolution 6-76.

COMMITTEE ON THIRD PARTY RELATIONS

Charles D. Hollis, Jr., M.D.

The committee met on March 11, 1976 with representatives of Medicare, Medicaid, CHAMPUS, Blue Cross of Atlanta, Blue Cross of Columbus, and HIAA. Matters of mutual interest between practicing physicians and third party carriers were discussed at some length.

MEDICARE

General Information: The Prudential Insurance Company, as agent for the Medicare program in Georgia, at present is handling about 125,000 claims per month. Sixty-seven percent of these claims are processed in 20 days or less, 84 percent in 30 days or less, and the remaining 16 percent over a longer period of time because of certain problems which probably should be pointed out.

The percentage of unassigned claims is increasing steadily, and when elderly people fill out their claim forms they frequently make errors. This necessitates a call to the doctor's office at considerable delay in the final payment of the claims. Frequent errors are: (1) omission of the claim number from the form; (2) failure to itemize charges; (3) failure of the claimant to sign the forms; (4) failure to list the dates of service; (5) omission of the Medicare provider number when the uniform claim form is used; (6) omission of either a code number or description of the service rendered, both of which are required by Medicare at the present time. It was also pointed out that there is confusion at times because the physician forgets that he is allowed to bill for the 20 percent co-insurance not paid by Medicare.

Thirty percent of the claims submitted to Medicare also have Medicaid coverage. Further delays result in certain situations: (1) a correct Medicaid number is not added to the form; (2) the physician does not state that he will accept assignment meaning that Medicaid will not handle the forms; (3) because of the Medicare program, at the time of processing a notice is sent that the required deductible has not been met, even in cases where Medicaid will cover this co-insurance, at times causing confusion.

Fees Under Medicare: During the past fiscal year fees were determined by fee profiles with the prevailing

level determined by 1974 charge data. Allowable payments were scaled according to four geographical areas, with the more densely populated areas, in general, and certain specialty designations being rated for larger payments.

For fiscal year 1976 there must be a reappraisal of schedules. The 75th percentile of the 1975 fee data must be compared to 1971 data. A fee no higher than 17 percent above the 1971 fee level, but no lower than the 1974 fee level, will be allowed. If an individual profile is lower than the prevailing rate in his geographical area, he may raise his fees to the prevailing level.

On July 1, 1976 there will be an update of profiles according to 1975 charge date.

Suggestions to the Practicing Physician:

1. Having the physician's insurance clerk fill out the form for the Medicare patient, whether he accepts assignment or not, will assure an improvement of the accuracy of the forms and expedite the processing of all claims.
2. Use the uniform claim form, if possible, but be sure to add the provider number supplied by Medicare.
3. Code and describe the services rendered.
4. Itemize charges.
5. Remember that it is allowable to bill for the 20 percent co-insurance.

MEDICAID

General Information: The Medicaid program in Georgia is handled under the Department of Human Resources. Three and a half million physician claim forms are submitted to the Medicaid office in Georgia each year, resulting in a payment of $45 million to physicians. The computer system had not been updated for Medicaid until this year, resulting in the processing time to about 12 to 14 weeks on an average. This is being corrected. By April, 1976, the handling of claims should be on a 30 day cycle. In all, 10 million claims are handled by the Medicaid office, with payment of $343 million to doctors and hospitals, nursing homes and others in Georgia.

Georgia Medicaid is now working under an HEW research grant for Medical Management Information Systems. The AMA uniform claim form does not meet the HEW requirements for information under the study and therefore is not acceptable for Medicaid's purposes.

Problems:

1. The most frequent problem is the omission or supplying of an incorrect Medicaid number on the claim form.
2. The Medicare portion of combined claims must be processed first, and some of their procedures are delayed by the filing of improperly completed information on the claim forms.
3. Sometimes there is confusion in the cross over between the four digit code of Medicare and the five digit code of Medicaid.
4. Sometimes there is delay in handling because forms must be submitted to the Foundations for determination of the appropriateness of service.
5. Occasionally fees are submitted which are completely out of line with the profile of similar practitioners, resulting in some review.

Fees Under Medicaid: Prior to April, 1976, fees were based on 1969 relative value schedules with state-wide

maximums. HEW found this method illegal and required Medicaid to change to a profile system of fee determination. Under the new system: (1) the median of usual charges for all similar physicians is chosen but it can be no higher than the fee under Medicare; (2) the state is divided into four geographical areas, identical to the areas of Medicare, and fees are scaled at the 75th percentile level of the prevailing fees for the area; (3) Medicaid can pay no more than the previous Medicare profile allowed and no more than the level of fees for fiscal year 1974; (4) the next update in profile will be in June, 1976.

Suggestions:

1. Use the CPT code for identifying services on the Medicaid form.
2. Be sure that information submitted to Medicare is complete and correct when the patient is covered by both Medicare and Medicaid.
3. Disregard the notice from Medicare stating that the deductible has been unmet when the patient is covered by both Medicare and Medicaid.

CHAMPUS

General Information: CHAMPUS handles 10 to 12 thousand claims per month with a processing time of about 30 days. About 25 percent of the forms are incorrectly filled out and must be resubmitted. The most frequent errors are failure of the patient to sign the form and the failure to include the necessary eligibility information.

CHAMPUS can no longer pay for counseling services.

If a patient resides within 40 miles of a military facility, he must use that facility except in cases of emergency, unless he receives a certificate of non-availability from the hospital commander.

Fee: Until January 1, 1974 fees were based on profiles developed for CHAMPUS. Payment was made on the basis of the 90th percentile.

Since January 1, 1976 allowable fees have been changed. The profiles are based on 1974 charge data and will be paid at the 75th percentile.

BLUE SHIELD OF ATLANTA

General Information: Blue Shield of Atlanta at present has about 46 percent indemnity plans and 54 percent usual customary and reasonable plans. There is no service feature. Beginning recently a comprehensive package of UCR plus a percentage of all the charges above that with a front end deductible is being made available.

Profiles are developed and based on the 90th percentile. Profiles are updated in April and October. The Atlanta Blue Shield plan utilizes the Foundations for consultation in disputes about whether or not a fee is reasonable.

The Atlanta Blue Shield handles about 20,000 per month and about one of seven of these has to be investigated for further information. Ten percent of the claims submitted are unacceptable and have to be resubmitted.

Some general problems include the following: (1) the contract number is incorrectly stated; (2) the date



Presented a 50-year pin at the 1976 Annual Session is Dr. Loree Florence of Athens, the first woman graduate of the Medical College of Georgia. She attends the President's Reception with a friend, Mrs. R. H. Garrett.

of birth is wrong; (3) in claims for services by radiologist and pathologist there is frequently no diagnosis; (4) charges many times are not itemized; (5) coding is omitted (even though this is not required it makes possible more precise identification of the service and also expedites claims handling); (6) the uniform claim form which would standardize the handling of the claims is not being generally used.

COLUMBUS BLUE SHIELD PLAN

General Information: Most of the Columbus Blue Shield contracts have been of a relative value system type with an increasing number of UCR contracts in the last year or two. Profiles have been developed on a general basis and the plan is now working toward a regionalization of the profiles. The fee data are updated every six months.

Columbus Blue Shield still has service contracts which are maintained in an effort to assure the patient that the entire bill will be paid. There has been discussion within the plan as to whether or not the service contract has fulfilled its purpose and should be eliminated in the future.

HIAA

General Information: The commercial companies offer both indemnity and major medical with a co-insurance feature. They use primarily the relative value system based on the 1969 California RVS.

All of the commercial companies now accept the uniform claim form and encourage its use.

Coding of services by the CPT system allows better definition of the service rendered and should be encouraged.

Coverage for Alcoholism: All major carriers now cover the alcoholic for acute hospital care. None, apparently, cover long term outpatient rehabilitation services.

Carriers are undecided at present about how much rehabilitation care should be offered and request that an appropriate MAG committee consider this and offer advice.

Fee Differential According to Geographical Areas: At the annual session of the MAG in 1975 concern was expressed because physicians with similar qualification performing similar services in geographical areas with smaller populations were frequently paid a lower fee under the present profile system. It was felt that this was discriminatory and might discourage physicians from entering practice in rural and underserved areas.

The fee differential according to geographical areas is national policy and cannot be altered at a state level. Apparently Senator Talmadge and his committee are familiar with the problem and are discussing possible remedies.

RECOMMENDATIONS

1. Refer the question of insurance coverage for rehabilitation and repeated hospital services for alcoholics to the mental health committee for study and report to Council.

2. Notify Senator Talmadge and the other Georgia Representatives in Congress that the present fee differential based on geographical areas is discriminatory and serves as a negative incentive for physicians to enter rural and thinly populated areas where their services are in great demand.

3. Reconsider the UCR concept as a method of determining fees, with question as to whether this method effectively avoids fee setting by the major carriers. Consider whether or not a system of fees based on the relative value system would be a better way of compensating physicians with similar qualifications offering similar services.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee wishes to offer special commendation to the chairman and to the Committee on Third Party Relations for its comprehensive report on problems of third party carriers including the methods by which they determine reimbursement to physicians. This report considered the question of the differentials based on geographical areas and the problem of covering long-term and rehabilitative services for alcoholics.

There was general agreement expressed during the Reference Committee hearings with the recommendations of this report. Several questions were raised concerning the use of a relative value study because of the recent actions taken by the Federal Trade Commission against certain national medical specialty societies. In spite of this activity at the national level, your committee felt that further study should be done by the Committee on Third Party Relations on the question of the use of a relative value system.

Mr. Speaker, your Reference Committee recommends approval of Recommendation 1, to refer the question of insurance coverage for alcoholic rehabilitation to the Mental Health Committee.

Your committee recommends approval of Recommendation 2, as this is a reiteration of the previously considered resolution of the Subcommittee on Rural Health.

Your committee recommends approval of Recommendation 3 for further study of the relative value system by the Committee on Third Party Relations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Third Party Relations.

RESOLUTION 8-76
MEDICAL ETHICS

James H. LaRose, M.D. and
Douglas G. Whitney, M.D.

WHEREAS, physicians have voluntarily under organized medicine set standards of ethics, morals and professional conduct, unique to the practice of medicine; and

WHEREAS, the ultimate goal and primary interest of the physician has been traditionally the welfare, health, and happiness of their patients in whatever commercial relationships they, as physicians, have entered into; and

WHEREAS, it has been acceptable and traditional for physicians to invest in and derive reasonable profits from ownership and operation of certain laboratories, hospitals, diagnostic and therapeutic equipment, etc., and

WHEREAS, physicians have traditionally attempted to maintain a practice of ethical and prudent behavior in these commercial relationships; and

WHEREAS, there have developed with the rapid advance of modern technology, new and novel instruments capable of providing a unique service of improved diagnostic and therapeutic capabilities; and

WHEREAS, such instrumentation and equipment should be made available for patient care; and

WHEREAS, because of multiple factors including capital outlays for such equipment, institutions in some cases are slow to provide these tools, or have been constrained from doing so by federal and local regulatory mechanisms; and

WHEREAS, physicians in many areas faced with the need, opportunity, and the foregoing difficulties, provided the necessary financing to practice and operate such equipment; and

WHEREAS, the potential financial reward to such physicians investors may be large in some circumstances, the possibility exists of distorting good and prudent medical judgement as well as ethical behavior inherent in such commercial relationships, therefore be it

RESOLVED, that the Medical Association of Georgia:

1. Direct the Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia to inform itself about this potential problem and report to the next meeting of Council of MAG, and subsequently, to the next meeting of the House of Delegates.
2. Encourage component medical societies where appropriate to join in such investigations.
3. Urge physicians cognizance of the *potential for* unethical practice with such modern and technical tools when the physician referring a patient for such a study can anticipate a profit from its use.
4. Insist on full disclosure to the patient in every instance as to the physician owners of such tools (individual and institutional) as well as, to separation of charges (i.e., professional charge for interpretation vs. non-professional charge).
5. Request the AMA Judicial Council to provide clear and concise guidelines of medical ethics relative to physician investors in the medical industry appropriate to heretofore traditional practices as well as current issues set forth herein.

REFERENCE COMMITTEE B

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, the subject of this resolution was without a doubt the most controversial one brought before your Reference Committee. Several members from the Medical Association of Atlanta spoke to this issue explaining the situation in their area. It was recognized by members from other county medical societies around the state that with the advent of certain highly sophisticated diagnostic equipment, problems could also occur in other areas of Georgia. Spokesmen for the Medical Association of Atlanta acknowledged that the questions that were being raised by this resolution were potential problems and not actual ones. There was a very sharp division among the individuals who spoke before your Reference Committee on this issue.

Your Reference Committee believes that it would be more effective for the Medical Association of Georgia to look into the questions raised by this resolution now rather than in retrospect. In addition, we agree that clear language must be enunciated by the American Medical Association in its Judicial Council's Opinions and Reports, in order to give guidance to its members. The committee also wishes to reaffirm MAG policy on the handling of ethical problems, i.e., whenever possible, these should be managed at the local level. Reference Committee B considered the possibility of amending the resolved dealing with full disclosure. It concluded that no practical means could be found for fulfilling the intent of this portion of the resolution.

Mr. Speaker, your Reference Committee makes the following recommendations: We recommend approval of the first Resolved with the deletion of the first word and the insertion of the word "Alert," the deletion of the words "to inform itself" and the insertion of a period after the words "potential problem," and deletion of the rest of that sentence. The first Resolved would then read: "Alert the Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia about this potential problem."

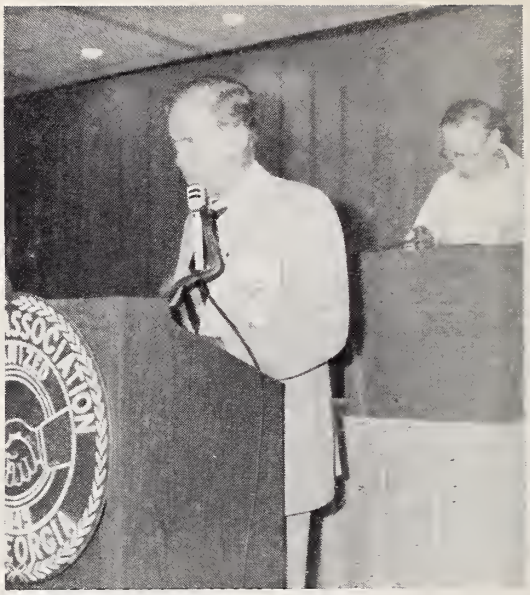
Your committee recommends disapproval of the second Resolved on county medical society investigations; disapproval of the third Resolved on the potential unethical practice of anticipating profit from use of modern technical tools; as well as disapproval of the fourth Resolved on full disclosure concerning physician ownership of such tools.

Your committee recommends approval of the fifth Resolved on clarifying AMA's Judicial Council's Guidelines.

HOUSE OF DELEGATES ACTION—Adopted resolution 8-76 with the following amendments by substitution and deletion: Re-write the first Resolve to read "alert the Professional Conduct and Medical Ethics Committee of the Medical Association of Georgia about this potential problem." Voted to not approve the second, third and fourth Resolves and approved the Fifth Resolve. With the above changes, Resolution 8 then was adopted.

Chairman Stephens expressed his appreciation to the members of the Reference Committee and to the MAG staff for their time and effort in the preparation of this report.





Chairman J. Kenneth McDonald of Reference Committee C reviews the blackboard list of items for consideration by his committee with (L-R) Rusty Kidd, staff, and committee members Roy W. Vandiver and Charles R. Richardson. During the Final Session of the House, presided over by Speaker L. C. Buchanan, Dr. McDonald reports the committees opinions and decisions.

REPORT OF REFERENCE COMMITTEE C

J. KENNETH McDONALD, M.D., *Chairman*

Chairman McDonald reported to the House of Delegates that the reports and resolutions referred to Reference Committee C had been considered by the committee which met at 2 p.m. in Colony Hall, Holiday Inn, Jekyll Island, Georgia on April 9, 1976. Members of the committee present included: J. Kenneth McDonald, M.D., Augusta, Chairman; Charles H. Richardson, M.D., Statesboro, Vice Chairman; Charles Hobby, M.D., Valdosta; James A. Kaufmann, M.D., Atlanta; Roy W. Vandiver, M.D., Decatur; and Frank Robbins, M.D., Hinesville.

COMMITTEE ON STATE LEGISLATION

James A. Kaufmann, M.D.

The 1976 Georgia General Assembly was the most hectic and confusing legislature MAG has had to deal with for as long as I can remember. Between malpractice, optometry, chiropractic, HMO and pharmaceutical legislation, your committee and especially your chairman and Rusty Kidd spent untold hours working to insure the success of the MAG legislative program.

During this session there were 56 bills that in one way or another affect the health care delivery system we as Georgia physicians provide. The active participation of the MAG on all legislation is and should be for the benefit of the patient.

This year, more so than in the past, the membership of our Association became active in communicating their wishes and ideas to not only their representative and senator but to the entire membership of the General Assembly. This is apparent by the overwhelming success of the legislative program of the Medical Association this year.

The physicians of Georgia owe a great deal of gratitude to Representative Tom Taggart, Savannah; Roy Lambert, Madison; Wilbur Baugh, Milledgeville; Wayne Snow, Chickamauga and Senator Ed Garrard, Atlanta, for their tireless efforts in behalf of medicine. We also owe thanks to a number of other representatives and senators who supported the position of the MAG. I hope each MAG member will take time to thank his legislator for his help, if in fact he did. Rusty Kidd can provide you with the information on how each legislator voted on health related issues. Feel compelled to obtain this information for this is an election year. Those legislators who are receptive to medicine's viewpoint need your help in their efforts to be re-elected for the 1977-78 legislative term. The physicians of Georgia can be very influential in a legislative campaign by working for and supporting the candidate of their choice.

Your Legislative Committee plans to become more active in political campaigns over the summer and urges every MAG member to actively support a candidate. If assistance is needed for ideas on how to help your candidate in his campaign, contact Jim Kaufmann.

The following is a list of legislation on which your Legislative Committee took action during the 1976 Georgia General Assembly.

S.B. 464 Malpractice—Statute of Limitations. Passed House and Senate, MAG strongly supported. This bill specifically states that all medical malpractice suits shall be filed within two years from the date of occurrence.

This is the strongest statute of limitations in the country. We can be proud of ourselves for passing this monumental bill.

H.B. 1446 Malpractice—Ad Damnum Clause. Passed House and Senate, MAG strongly supported. This stated in all medical malpractice suits filed in excess of $10,000, no dollar amount could be stated. In essence this will prohibit the filing of a suit for $2 or $3 million which will cut down on the amount of publicity.

S.B. 465 Malpractice—Arbitration. Passed Senate. MAG supported. After S.B. 465 passed the Senate a substitute version was presented to the House Judiciary

Committee. This version is a very massive piece of legislation which will permit the signing of a voluntary binding arbitration agreement before and/or after treatment has been rendered. The Judiciary Committee thought it best to study this 33 page bill, perfect it and reintroduce it in 1977 and seek its passage then.

H.B. 1445 Malpractice—Report to Board of Medical Examiners. Passed House, MAG supported. This strictly medical housekeeping bill was defeated by the Senate Judiciary Committee. H.B. 1445 simply stated on all cases settled in court against a physician on a medical malpractice suit the court would notify the Board of Medical Examiners of the court's decision. The Board is the licensing agency for physicians in Georgia and if a physician has done wrong on several occasions, this agency should be notified.

H.B. 757—Health Maintenance Organizations. Passed House, MAG opposed. This permissive bill, which MAG objected to, was put into a study committee by the Senate Human Resources Committee. MAG's position on HMOs is if a bill must pass, it should include certain points. H.B. 757 did not. An HMO bill may pass the legislature in the near future.

H.B. 1618 Illegal Practice of Medicine—Felony. Passed House and Senate, MAG strongly supported. Current Georgia law states if someone practices medicine without a license it is a misdemeanor. H.B. 1618 changes this illegal practice to a felony. The Board of Medical Examiners and your local district attorneys agree with MAG that this was needed.

H.B. 1705 Generic Drug Substitution. Defeated by House Committee, MAG vigorously opposed. This extremely broad legislation would have required the pharmacist to substitute for your prescription the least expensive drug available. If this was not done the pharmacist would be fined $100. MAG felt this or any blanket drug substitution would remove the control of patient care from the physician.

H.B. 1750 Atlanta Blue Cross-Blue Shield Merger. Passed House and Senate. This bill, introduced late in the session, legally permitted the Atlanta Blue Cross and Blue Shield to merge, alter the make-up of the Board, permit establishment of HMOs and sell life insurance. MAG opposed the HMO aspect of this bill and had a number of questions about the remainder of H.B. 1750. Due to the lateness of the session and the urgency of the Insurance Commissioner, we opposed the HMO aspect, which was deleted, and took no position on the remainder of the bill.

H.B. 1756 Family Practice Advisory Board. Passed House and Senate, MAG strongly supported. This bill, supported by the Georgia Academy of Family Physicians, will create a Family Practice Advisory Board to assist in the regulation of Family Practice Residency Programs throughout Georgia. Hopefully, when funds become available this Board can help channel this money to the Medical College of Georgia's Department of Family Practice to produce more family physicians for Georgia.

H.B. 1907 Radiation Control Act. Passed House and Senate. The original version of this bill would have put control of all radioactive materials under the supervision of the Environmental Protection Agency Division of the Department of Natural Resources. Currently control of radiation usage by physicians offices and hospitals comes under the Department of Human Resources.

REFERENCE COMMITTEE C

The Georgia Radiological Society was opposed to this transfer of authority and, along with MAG, was successful in keeping control of all medical usage of radiation under DHR while all other radioactive usage will be under the control of the Department of Natural Resources.

H.B. 88 Optometry. Amended version passed House and Senate, MAG vigorously opposed. MAG has been plagued by this bill for a number of years. The original version stated "it shall be unlawful for any State board, body, agency of State government, public official or state institution to discriminate against an optometrist or a physician in the recommendation of visual care." There was a penalty section permitting injunctive relief, a section permitting physicians to recommend whomever they wanted and a section permitting those with custodial care to recommend whomever they desired.

The injunctive relief section was deleted which made H.B. 88 less offensive. This bill was and still is vague and leaves for determination *what* constitutes discrimination. Hopefully, the Governor will veto H.B. 88.

S.B. 437 Clinical Laboratories. Amended version passed House and Senate. The original version would have allowed all DHR, U.S. Government and Medical College of Georgia labs from conforming to the clinical laboratory rules and regulations promulgated by the Department of Human Resources. This version MAG opposed.

The final version, on which MAG took no position, removed from the current Clinical Laboratory Act all labs at the Medical College of Georgia, Emory Medical School and any other medical school in Georgia.

S.B. 603 Emergency Medical Technicians. Passed House and Senate, MAG supported. This bill provides for certification of all EMT personnel. This certification will be regulated by the Board of Medical Examiners. Hopefully, under this Act all EMTs will be better trained and will be of more assistance to those in need.

S.B. 633 Telephone Answering Service. Passed Senate, MAG supported. This bill was designed to ease potentially difficult situations when the telephone company found it necessary to terminate services to an answering service which had physicians and dentists as its clients. The telephone company is required to notify the answering service and the Public Service Commission by registered mail at least 10 days prior to the termination of service. S.B. 633 made it a misdemeanor if the answering service did not notify its subscribers before the service was terminated and would make the service liable for any damages arising if their subscribers had not been notified. This bill passed the Senate and House committee but was not called for a vote on the final day. We will try again next year.

S.B. 694 Abortion. Failed in committee, MAG opposed. This entire rewrite of Georgia's abortion law was defeated in the Senate Judiciary Committee.

Board of Medical Examiners Appropriation. Passed House and Senate, MAG strongly supported. The Composite State Board of Medical Examiners was in dire need of additional funds to hire investigators, etc. Working closely with the Board we were successful in obtaining $155,000 more in appropriations for the Board than last year.

H.B. 2084 Drivers License—Physicians Reporting. This bill had the concurrence of the Department of Public Safety. Unfortunately, it was introduced late in the session, and time alone defeated H.B. 2084.

This bill would have changed current law which states physicians "shall report to the Department of Public Safety" to "may report" those 15 years of age and older who have a disability which may limit their ability to drive an automobile safely.

RECOMMENDATIONS

1. MAG obtain a list from every county medical society of that county's non-MAG members so the Legislative Committee can urge their membership in MAG.
2. Urge every MAG member to write the only Georgia physician in the legislature, Wilbur Baugh, commending him for his time and effort in public service.
3. Urge more participation in Georgia's political scene by physicians running for office or by active support of physicians for those who seek office and are friendly to the viewpoint of the MAG.
4. Request every specialty society of the MAG to become as active as the Georgia Psychiatric Association in the overall objectives of the MAG on its legislative programs.

REFERENCE COMMITTEE RECOMMENDATION —(a) Your Reference Committee recommends adoption of Recommendation 1 but amended to read as follows: "MAG should obtain a list from every county medical society of that county's non-MAG members so the Legislative Committee can urge their membership in MAG, in conjunction and coordination with the Membership Committee.

(b) Your Reference Committee recommends adoption of Recommendation 2, to be amended as follows, "Urge every MAG member to write the only Georgia physician in the legislature, Wilbur Baugh, commending him for his time and effort in public service and instruct MAG staff to urge the secretary of every county society to write Dr. Baugh in behalf of the membership of their county society."

(c) Your Reference Committee recommends adoption of Recommendations 3 and 4 as written.

Your Reference Committee urges an additional fifth recommendation to the report. S.B. 437 on Clinical Laboratories should be referred by Council to the appropriate MAG committee for further study and recommended Council action.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on State Legislation as amended by the Reference Committee.

COMMITTEE ON MATERNAL AND INFANT HEALTH

Luella M. Klein, M.D.

CALENDAR YEAR 1974

LIVEBIRTHS AND BIRTH RATE

There were 83,652 livebirths in Georgia during fiscal 1974. The birth rate decreased to 17.1 (17.8 in 1973), due to a decrease in the white livebirth rate to 14.9 and in the black rate to 23.5. (Preliminary data indicates that there was again a decrease of total livebirths in 1975.)

Hospital deliveries reached a high of 99.3 percent. There were 365 livebirths at home attended by lay midwives in 1974 and 1,128 deliveries in hospitals by certified nurse midwives.

BIRTHS TO UNWED MOTHERS

There were 11,672 livebirths to unwed mothers, 14 percent of livebirths during 1974, 2,039 to white unwed mothers and 9,633 to unwed black mothers.

ADOLESCENT PREGNANCIES

Livebirths to adolescents comprised 25.3 percent of all livebirths in 1974. There were 9,755 livebirths to mothers 17 years of age or less and a total of 21,195 adolescent livebirths. Fifty-six percent of all livebirths to unwed mothers were to adolescents.

Teenage pregnancy is a serious social and health problem in this state. Almost one out of every 10 girls aged 15-19 in Georgia had a baby in 1974. (Source: Abstract of paper, "Estimated Costs and Benefits of Public Family Planning Programs in Georgia," by Rebecca B. Cox and Anne W. Wheeler, State Center for Human Service Statistics, Department of Human Resources.)

There are an estimated 76,000 teenage girls in Georgia who are sexually active and thus potentially at risk of pregnancy. Slightly more than one-third of these teenagers were actively enrolled in the state's public family planning clinics in 1974.

It is estimated that if all sexually active teenagers had been enrolled in a family planning program in 1974 and had continued use of an effective, medical method of contraception, 14,000 unwanted pregnancies could have been prevented (4,700 illegitimate births, 5,700 induced abortions, and 4,000 other unwanted pregnancies). Because of the higher medical risks associated with births to teenagers, simply delaying their childbearing until age 20-24 would have resulted in an estimated 143 fewer infant deaths and 764 fewer premature births in Georgia.

Another benefit of delayed childbearing is the greater likelihood that a teenager will remain in school. According to the Department of Education, there were 10,478 girls aged 12-17 in Georgia who dropped out of school in 1974. Although statistics are not available showing the number who withdrew because of pregnancy, we do know that there were 9,698 births in this age group in 1974. U.S. Bureau of Labor statistics show that the unemployment rate of women who did not finish high school is twice that of women who completed a high school education. Loss of a woman's potential earnings and contribution to the public tax base is one element of the monetary cost to the public of teenage childbearing.

INFANT HEALTH

In Georgia over the past 20 years, we have seen a decline in the birth rate: 27.3 per 1,000 population in 1954 to 17.1 per 1,000 population in 1974. Similarly, we have seen decreases in infant, neonatal, postneonatal, and prematurity death rates. For example, infant mortality dropped from 31.5 per 1,000 livebirths in 1954 to 18.0 per 1,000 livebirths in 1974; and neonatal mortality declined from 21 per 1,000 livebirths to 12.6 per 1,000 livebirths.

INFANT HEALTH AND AGE OF MOTHER

An attempt has been made to determine the level of premature births, birth injuries, congenital anomalies and complications of the mother related to age of the mother for both the black and white populations. Table 1 displays the relationship of age of mother to the variables mentioned above.

The relationship of prematurity, birth injuries, congenital anomalies, complications of the mother related to age tend to be highest among children born to the youngest mothers (under 16, 16-19) and to those of the oldest (over 35). This is true for both racial groups in all categories except prematurity. The risk for black mothers is generally higher.

INFANT HEALTH AND GRAVIDITY OF MOTHER

An analysis of 80,560 births in 1974 concerning the gravidity of the mother and selected conditions at birth reveals interesting relationships. Table 2 summarizes four conditions related to gravidity of mother: prematurity, birth injuries, congenital anomalies, and complications of mother. The trends evident for these conditions are, in many instances, similar to those attained for age of the mother.

Premature births increase as the gravidity of the mother increases for the white population. However, prematurity in black births appears not to be related to gravidity of the mother but is more than twice that of the white in all births up to 4.

The relationship of birth injuries to gravidity of mother is peculiar when categorized by race, two patterns are evident. Birth injuries increase with increased gravidity of the mother for the white population, while birth injuries decrease with increased gravidity of the mother for the black population.

A trend is very evident for congenital anomalies and gravidity of mother for both population groups; that is, the percentage of congenital anomalies increases with corresponding increases in the gravidity of the mother. The percentages for the white population range from 1.87 to 5.60, while the black values range from 1.98 to 4.27. The frequency of complications of the mother relative to the gravidity of the mother is concentrated in the less than 2 and less than 4 gravidity groups, regardless of race.

MATERNAL MORTALITY

In Georgia, maternal death rates have declined from 10.9 per 10,000 livebirths in 1954 to 2.0 in 1973; however, the rate increased to 3.2 in 1974. The United States' rate shows a corresponding decrease of 5.2 to 1.5 for 1954 to 1973, but the rate also increases to 2.1 for 1974.

There were 27 maternal deaths in Georgia in 1974. Toxemia was the principal factor in the death of six black women (ages 16, 19, 21, 21, 25 and 32), although in one of these cases the immediate cause was an anesthetic accident. Ectopic pregnancy took the lives of another six black women (ages 19, 20, 26, 30 and 32, and unknown). Pulmonary embolus caused the deaths of three white (ages 31, 32 and 33) and three black women (ages 20, 25 and 27). In the deaths of two white women, amniotic fluid embolism was the cause, while in the others vascular thrombus was found. Hemorrhage was the cause of four black (ages 31, 33, 34 and 40) and one white (age 39) deaths. Fibrinogen deficiency contributed to the white and one black death. Rupture of the uterus caused two deaths in white mothers (ages 26 and 38). Legal abortion was the cause of death for two black women (ages 18 and 23), one of which was a second trimester abortion.

ABORTIONS

In calendar year 1974, there were 22,009 legal abor-

TABLE 1. PERCENTAGE DISTRIBUTION OF SELECTED CONDITIONS RELATED TO BIRTH AND PREGNANCY, BY AGE GROUP AND RACE OF MOTHER GEORGIA, 1974

Condition	Total, All Ages (N=80,560) (%)	Age Group of Mother <16 (N=2,341) (%)	16-19 (N=18,767) (%)	20-24 (N=27,977) (%)	25-29 (N=20,713) (%)	30-34 (N=7,753) (%)	>35 (N=3,009) (%)
Immaturity							
Total	8.40	15.50	10.50	8.10	6.70	7.50	9.00
White	6.07	11.92	7.31	5.57	5.33	6.20	7.77
Black	12.96	17.30	14.27	12.80	10.88	11.28	10.90
Birth Injuries							
Total	1.85	2.30	2.04	1.86	1.60	1.75	2.19
White	1.65	1.14	1.89	1.61	1.52	1.66	1.95
Black	2.22	2.90	2.19	2.32	1.88	2.02	2.43
Congenital Anomalies							
Total	1.91	2.43	1.98	1.94	1.69	1.94	2.35
White	1.85	2.41	1.80	1.94	1.67	1.81	2.46
Black	2.03	2.45	2.20	1.92	1.68	2.26	2.26
Complications of Mother							
Total	14.10	16.80	14.40	13.30	13.80	14.90	17.40
White	13.46	15.73	13.66	13.02	13.37	13.86	15.44
Black	15.27	17.30	15.20	13.88	15.17	17.79	20.38

N = number of observations.
Source: Health Services Research and Statistics Section.

tions reported to the Department of Human Resources; 17,389 were residents of Georgia; 4,620 were out-of-state residents. This is a ratio of 208 abortions per 1,000 livebirths. There was one maternal death caused by sepsis following legal abortion, and a second death probably due to water intoxication following a late saline induced abortion.

Thirty-four percent of women aborted were under 20 years of age, and 43.5 percent had no children. Sixty-six percent were white and 34 percent black and other.

By estimated duration of pregnancy 90.1 percent were under 13 weeks, 6.3 percent were 13-20 weeks, and 0.3 percent greater than 20 weeks.

PUBLIC HEALTH MATERNAL HEALTH SERVICES

During FY 1974, 16,981 women received prenatal care through county public health departments; 16,001 were new admissions and 3,980 were carried over from the previous year. By gestational duration at time of admission, 41 percent were admitted under 16 weeks compared to 30 percent the previous year.

During FY 1974, a new Department of Human Resources program—maternity care for the medically indigent—was inaugurated. This program (MAT-PAK) provided limited payment to physicians and hospitals for delivery of medically indigent women. During the period September 1973 through January 1975, 3,079 women received services (1,635 white and 1,367 nonwhite). The program has been modified to provide for services to medically indigent high risk mothers and their infants.

FAMILY PLANNING

As of June 30, 1975, there were 109,952 women actively participating in the Department of Human Resources' statewide Family Planning Program (1974—84,250). During fiscal year (1975) there was an unduplicated total of 126,400 patients, served through 274,184 visits. By age grouping, 34.2 percent of the active patients were under 20 years of age; 32.7 percent between 20 and 24 years of age and 33.1 percent were aged 25 and over. Oral contraceptives were chosen by 76 percent of the patients served, intrauterine devices by 12 percent and other methods by 12 percent. During the fiscal year 614 sterilization procedures were paid for out of program funds.

NUTRITION AND WIC

Nutritional care for the pregnant woman is coordinated with overall maternal health care by the two nutrition consultants in the Maternal Health Section. Planning, implementing and evaluating nutritional components of statewide plans as well as providing inservice programs to nursing personnel at the local level are among their primary duties.

One of the statewide programs, the Special Supplemental Food Program for Women, Infants and Children (WIC), served an average of 6,382 participants monthly from July, 1974 through June, 1975 with an average of 1,340 pregnant or lactating women, 1,989 infants and 3,052 children. Sixty-two counties and three health agencies were WIC sites.

Each participant is eligible to receive milk, cereal, fruit juice, eggs, cheese or infant formula and cereals through either a food delivery system (99.1 percent participation) or a food coupon system (75 percent redemption).

Meeting the nutritional needs of this target population of pregnant or lactating women, infants or children determined to be at nutritional risk through the WIC Program is an attempt to prevent undernutrition and possible stunting of physical and mental growth

TABLE 2. PERCENTAGE DISTRIBUTION OF SELECTED CONDITIONS RELATED TO BIRTH AND PREGNANCY, BY GRAVIDITY AND RACE OF MOTHER GEORGIA, 1974

Condition	Total Gravidity (N=80,560) (%)	Gravidity of Mother <2* (N=35,907) (%)	2-4 (N=38,606) (%)	>4 (N=6,047) (%)
Immaturity				
Total	8.40	7.85	8.62	11.11
White	6.07	5.61	6.10	9.83
Black	12.96	12.38	13.68	12.25
Birth Injuries				
Total	1.85	1.83	1.81	2.19
White	1.65	1.54	1.66	2.47
Black	2.22	2.40	2.11	1.97
Congenital Anomalies				
Total	1.91	1.90	1.46	4.91
White	1.85	1.87	1.43	5.60
Black	2.03	1.98	1.51	4.27
Complications of Mother				
Total	14.10	15.97	12.22	15.09
White	13.46	15.19	11.67	15.04
Black	15.27	17.51	13.25	15.11

N=number of observations.

* Because of coding instructions on the birth certificate, the column "<2" is subject to error; therefore, interpret results with caution.

Source: Health Services Research and Statistics Section.

during the periods of most rapid growth—pregnancy, infancy and early childhood.

RECOMMENDATIONS

1. That MAG support continued development of programs improving maternal and infant health care in Georgia.
2. That MAG support continuing development of regionalization of care for high risk mothers.
3. That MAG support continuing development of regionalization of care for high risk premature and newborn infants.
4. That MAG support the request to the legislature of the Georgia Council on Maternal and Infant Health for funds for care of indigent and medically indigent mothers and infants in Georgia (MAT-PAK).
5. That MAG support improvement in insurance coverage for obstetric care.
6. That MAG support an active aggressive health education committee to look into teenage pregnancy, teenage abortion and other aspects of teenage sexuality in Georgia. (The M & I Welfare Committee believes that these teenage health problems constitute one of the gravest health problems in Georgia and that MAG interest and action could be most beneficial.)

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends approval of Recommendation 1 as written.

Your Reference Committee recommends that recommendations 2 and 3 be combined to read: "(2) That MAG support development of care for high risk mother and premature and newborn infants. This should be accomplished in a manner that follows normal referral patterns which may or may not comply with designated health areas but rather protects the well-being of the patient."

Your Reference Committee recommends that these recommendations be renumbered as follows: 4 renumbered to 3; 5 renumbered to 4; 6 renumbered to 5.

Mr. Speaker, your Reference Committee recommends adoption of the Committee on Maternal and Infant Health report as amended.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Committee on Maternal and Infant Health as amended by the Reference Committee.

COMMITTEE ON NATIONAL LEGISLATION

Harrison L. Rogers, Jr., M.D.

Every year Congress acts on more health related bills than the previous year. Each of these medical bills should be of concern to every physician in Georgia. The American Medical Association has information regarding each of the more than 2,000 medical bills currently pending in Congress. The AMA is in direct contact with the MAG on many of the more important bills weekly. This increased communication between the AMA and the MAG is valuable and is needed for Georgia physicians to be able to contact our Congressmen as to our wishes.

The following is a list of Congressional bills which are of concern to MAG.

HEALTH MANPOWER (H.R. 5546)

A Health Manpower Act has been debated in Congress for the past several years. This year Senator Kennedy did not push his bill but waited for H.R. 5546 to pass the House, which it did. Senator Kennedy now hopes to amend H.R. 5546 to incorporate many of his ideas regarding health manpower.

The MAG and the AMA have taken a strong stand of opposing the control of residency programs, mandatory service of students, student paybacks and federal licensure and relicensure.

H.R. 5546 as it passed the House did not include controls on residency training programs or provisions for federal licensure or relicensure of physicians. Currently Senator Kennedy is considering amending H.R. 5546 in the Senate to include residency training and federal licensure.

Your committee will keep you abreast of any changes and, if need be, ask every MAG member to contact Senator Talmadge and Senator Nunn regarding H.R. 5546, as we did before the House considered this bill.

HEALTH MAINTENANCE ORGANIZATIONS (H.R. 7847)

This bill which makes it easier to establish an HMO has passed the Senate Labor and Public Welfare Committee and should be voted on by the entire Senate this summer.

H.R. 7847, which amends current law, would have the effect of reducing the minimum benefit qualification requirements of HMOs for federal support. It would also modify some of the rules of HMO qualification for grants, contracts, loans and loan guarantees under that program and extend the program for two years.

Under this new plan an HMO must provide basic health services which would consist of: physician services; inpatient and outpatient hospital services; diagnostic laboratory and diagnostic therapeutic services; preventive services (immunizations, well-child care from birth, periodic health evaluations for adults, voluntary planning services, infertility services, and children's eye examinations to determine need for eye correction). Other benefits currently defined as basic health services are medical treatment and referral services for the abuse of or addiction to alcohol and drugs, home health services, and preventive dental care for children.

The requirement that medical groups must have as their principal professional activity the provision of health services to members of HMOs would be eliminated.

The federal support program for HMOs would be extended for two years: for loan guarantees to June 30, 1978; for planning projects to June 30, 1978; for development projects to June 30, 1979.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (H.R. 5528)

This bill, totally endorsed by the MAG and the AMA, would amend the current PSRO law in 13 different ways.

Dr. L. C. Buchanan, in behalf of MAG, appeared before the Health Subcommittee of the House Committee on Ways and Means concerning MAG's support for H.R. 5528. Dr. Buchanan's prepared testimony was:

REFERENCE COMMITTEE C

"We support the 19 amendments endorsed by the American Medical Association and introduced as H.R. 5528. We cannot say that the amendments offered are going to completely satisfy our objections—they do, however, make needed changes. I would now like to review some of these amendments and tell you why we support them.

"If the medical profession is to have meaningful input to the establishment of utilization review and quality assurance programs, we must have an extension of the implementation deadline past the January 1, 1976 date.

"We are all aware of the fiscal challenges facing every segment of our economy today. It would seem prudent to use available funds to make fully operational those PSRO units now funded. A two-year delay in the implementation date would allow the economy to improve and ease the strain on federal outlays. Additionally, this delay would give future applicant organizations the benefit of several years experience by the currently funded PSRO's.

"Congressional intent seems clear in that Section 249F was meant to be the principal vehicle for the review of professional services under Title XVIII, XIX and V of the Social Security Act. Bearing this in mind, I wish to point out that numerous other bureaus and agencies have presented utilization review procedures pursuant to other sections of Public Law 92-603 and these conflicts seem certain to add to the complexity of a program already suffering from lack of definitive direction. It appears that Sections 207, 237 and 239 specifically provide variations to the intent of Section 249F. Each of these sections provide for the promulgation of review procedures for Title XVIII, XIX and V in conflict with the authority granted to the PSROs for this same purpose. Such variations in direction have created confusion now with only a small number of active PSROs—one can only speculate at the magnitude of the problem under full scale implementation.

"Another extremely important issue is that of confidentiality of information. Section 1155 requires the development and review of patient profiles of care. This means that the system would maintain records of all care delivered and payments made in behalf of some 35 million Medicaid and Medicare beneficiaries and recipients. Aside from the staggering costs involved, there is strong prospect for abuse of this massive computerized system of questionable value.

"Section 1156 dealing with the development of norms of health care services is unclear as to where the responsibility lies for the development of these norms. The AMA amendment that addresses this subject would clarify this question and allow for the input of national medical specialty organizations and state medical societies. National, state and local medical associations and specialty societies have a great wealth of expertise that should be used by the PSRO.

"While I am on the subject of medical organizations, let me make note of our concurrence with the amendment calling for the expansion of the scope of qualified organizations under Section 1152. We think that foundations for medical care designated by state medical societies should be eligible for consideration as a PSRO. We have a most active foundation for medical care in Georgia. As stated, I have had the privilege to work closely with our foundation and I can tell you that it is an excellent example of how true peer review can and should work.

"There is a section of 249F dealing with pre-admission certification for institutional care. We are unalterably opposed to this section. Physicians are capable and have the right to judge the advisability of admitting patients. We are, of course, prepared to submit our judgments and work to true peer review. Pre-admission certification potentially jeopardizes the well being of patients by delaying care. This is an unnecessary gamble to take with our patients and we urge your consideration of the amendment in H.R. 5528 to remove this section.

"Another section of 249F which we find particularly offensive provides for financial penalties to be levied against physicians judged to be in violation of the PSRO law's provisions. Although we recognize the necessity for penalties in the PSRO law, we do not believe that financial ones are the real answer. It would be much more effective to depend upon a process for suspension or termination of a provider from the Medicare and Medicaid programs if he is found by true peer review to be abusing them. H.R. 5528 includes in Section 6 a system of graduated sanctions which we believe would better serve the government and have a greater impact on providers."

This year two amendments to the PSRO law have been enacted. One is to change the implementation deadline from January 1, 1976 to July 1, 1978. The other is to permit a single state to serve as a PSRO area.

Additional bills have been introduced to amend the PSRO law. We will keep abreast of their status and their purposes.

NATIONAL HEALTH INSURANCE

Currently there are five major bills pending in Congress relative to National Health Insurance. The AMA version is H.R. 6222.

The Subcommittee on Health of the House Ways and Means Committee is holding regional hearings throughout the country. At most of these hearings well over 100 individuals and organizations have indicated they wanted to present testimony before the Committee. Most of the testimony is not totally against NHI but there are grave reservations about the ultimate cost —which no one is able to accurately estimate.

H.R. 6222, introduced by Representative Fulton of Tennessee, carried with it his comments. "This is not simply a tinkered-with version of Medicredit. It represents the evolution of the doctors' thinking, and demonstrates that the continuing process of discussion and debate has influenced the doctors as, indeed, it has influenced the thinking of Congress."

The general approach for H.R. 6222 is in four different plans with identical benefits "available to" but not mandatory for (1) employees, (2) non-employed and self-employed, (3) some unemployed, (4) aged. Medicare would be unchanged. The role of the federal government would be limited to: (1) subsidizing private insurance with no voice in cost containment, quality/availability of services; (2) paying for high-risk groups; (3) recommending state standards; (4) enacting legislation.

As you will note this is a brief capsule of the AMA National Health Insurance legislation. A more detailed

summary with a comparison of the other NHI bills is available through MAG.

It is anticipated that within the next two years some version of NHI will pass Congress. As of today, no one knows what that version might be; we can only hope it is similar to H.R. 6222.

ADMINISTRATIVE RULEMAKING
(H.R. 3658, H.R. 10301, S. 2716)

Georgia Congressman Elliott Levitas of DeKalb County introduced the original Administrative Rulemaking bill, H.R. 3658. This bill would provide Congress an opportunity to review and approve or disapprove administratively adopted federal regulations before the regulations could go into effect.

Rules affected by H.R. 3658 are those which are required to be published in the "Federal Register" and which would subject a person who violates them to a criminal sanction. An agency's rules could not go into effect unless a period of 30 consecutive days of Congress had expired and neither the Senate or House passed a resolution opposing the rule.

The AMA has introduced their version, H.R. 10301. The basic difference between Representative Levitas' bill and the AMA bill is that H.R. 10301 would (1) force the inclusion of contracts, loans, grants, benefits and public property under the rulemaking process to prevent substantive program changes through activities which are not subjected to regulation procedures; (2) expand the time limit for public comment on proposed regulations from 30 to a minimum of 60 days; and (3) require full disclosure of reasons for not including certain activities in the rulemaking process; for acceptance, rejection, or modification of submitted comments; and for denial of an individual's petition for a hearing to change regulations.

S. 2716 was introduced by Georgia Senator Sam Nunn. This bill combines aspects of both H.B. 3658 and H.R. 10301. S. 2716 has the 60 day waiting period and it applies to all proposed rules and regulations, not just those whose violation carries a criminal penalty.

Serving as Chairman of the MAG National Legislative Committee, I had the pleasure of appearing before the Subcommittee on Oversight Procedures to testify in behalf of MAG on S. 2716. This I did and stated that MAG was in full support of a bill of this type which would return government to the elected representatives of the people.

As of yet none of these bills has passed, but it is assumed one will pass within the next year.

Your National Legislative Committee has been more active this year than in the past. The Committee, acting for MAG, has sent a Georgia physician to Washington on five different occasions this year to testify before a committee or to talk to our Congressmen about a specific issue. On a whole, the reception we have received from our delegation has been more than adequate.

Our plans this year are to deviate from the past by not sponsoring a Congressional Luncheon in Washington. We plan instead to send a representative of MAG, either a physician and/or staff person to Washington periodically to contact our Congressmen and let them know our position on issues. Our hopes are that these trips will better utilize our budget for a more responsive Congressional vote on issues of concern to MAG.

REFERENCE COMMITTEE C

RECOMMENDATIONS

1. Commend Mr. Kidd for his vigorous and successful work in the area of both state and national legislation.
2. Recommend that each county society urge its membership to know their congressmen and senators and to actively participate in their campaign.
3. Recommend that each county society have several of their members contact their congressmen and senators regarding how specific national legislation affects the physicians in their district.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends adoption with commendation of Dr. Roger's Committee on National Legislation report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on National Legislation.

RESOLUTION 3-76
REPORTING HANDICAPS OF DRIVERS

David E. Dalrymple, M.D.
Medical Association of Atlanta

RESOLVED, that we, the members of the Medical Association of Georgia, do hereby strongly recommend that Georgia Code Section 68B-217 (Georgia Law which requires that physicians report to the Georgia Department of Public Safety those persons whose health might present a driving hazard), be rewritten so that this law becomes permissive rather than mandatory.

RESOLUTION 11-76
DRIVER'S LICENSE ADVISORY BOARD GUIDELINES

DeKalb Medical Society Delegation

WHEREAS, in 1975 the Georgia General Assembly enacted into law Section 68B-217 of the Georgia Code requiring physicians to "report to the Department [of Public Safety] in writing, the full name, date of birth and address of every person over 15 years of age diagnosed as having any such specified disorder or disability [as defined by the Driver's License Advisory Board] within 10 days after such diagnosis;" and

WHEREAS, the Executive Committee of MAG did point out to the Department of Public Safety the impossibility of compliance with this law and its many inherent dangers; and

WHEREAS, the Department of Public Safety did sponsor a change in the law making reporting permissive rather than compulsory, but this failed to be acted upon due to the lack of time; and

WHEREAS, the proposed revised act still identifies the physician as the prime reporting agent, which still carries considerable medical-legal risks and ethical conflicts, therefore, be it

RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record as opposing the law in its present form; and be it further

RESOLVED, that the leadership and staff work toward amendment of the law in the next session of the Georgia General Assembly in a manner which would:

1. Permit any concerned person, including but not specifying physicians, to report to the Department of Public Safety any person whose ability to drive is impaired in any way as to be a hazard. (This could be patterned after the child abuse laws.)

2. Provide adequate safeguards against both criminal and civil liability to any individual or agency making such a report.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee considered Resolution 3-76 and Resolution 11-76 together. We recommend Resolution 3-76 be received for information, and adoption of Resolution 11-76 by the DeKalb County Medical Society Delegation with one amendment. As amended, article 2 of the resolve would read, (2) "Provide adequate safeguards against both criminal and civil liability to any individual or agency making such a report or failing to make such a report."

HOUSE OF DELEGATES ACTION—Voted that Resolution 3-76 be received for information and to adopt Resolution 11-76 as amended in the final resolve by the Reference Committee.

LIAISON COMMITTEE TO THE BOARD OF HUMAN RESOURCES

George F. Green, M.D.

The physician members of the Board of Human Resources should be commended for the tremendous amount of time and study they furnish for an almost impossible task. MAG is especially fortunate to have this committee chaired by Dr. Joe Turner of Tifton.

Due to the complexities of the Department, the huge and unmanageable size of the Department and the stipulations of the federal regulations, they can only attempt to modify many distasteful regulations.

The input of the Advisory Committee gives these physician members of DHR other viewpoints that may influence their recommendations to the entire board. As for liaison with MAG there is none so the actual policies cannot be stated, only the opinions of individual advisory board and physician board members.

The Liaison Committee represents a good cross section and four of the members have been present for the majority of the meetings.

RECOMMENDATIONS

1. That Liaison Committee be continued.
2. That the less active members be replaced.
3. Active liaison and direction from MAG is necessary for your liaison committee to communicate MAG's opinion to the Board of Human Resources and its Medical Advisory Committee. It is therefore our recommendation that your liaison committee be invited and have a space on the agenda of every MAG Executive Committee and Council meeting.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends adoption with commendation of the report of Dr. George Green's Liaison Committee to the Board of Human Resources.

HOUSE OF DELEGATES ACTION—Adopted the report of the Liaison Committee to the Board of Human Resources.

RESOLUTION 12-76 AMA MEMBERSHIP OPINION POLL REGARDING NATIONAL HEALTH INSURANCE

DeKalb Medical Society Delegation

WHEREAS, the American Medical Association has been given a charge by its House of Delegates that "the membership be polled for their opinions on critical issues facing the medical profession," and

WHEREAS, previous polls conducted by AMA have not asked the membership whether they favor National Health Insurance or whether they feel that the AMA should sponsor a National Health Insurance Plan, and

WHEREAS, neither the economy nor the presently available health manpower can withstand the advent of National Health Insurance resulting in rationing of health care and leading to unnecessary suffering and financial burden for our patients, and

WHEREAS, the implementation of National Health Insurance is the most important issue facing organized medicine today, therefore be it

RESOLVED, that the Medical Association of Georgia take a firm stand against National Health Insurance in any form, and be it further

RESOLVED, that MAG go on record in opposition to AMA's sponsorship of a National Health Insurance proposal, and be it further

RESOLVED, that MAG introduce a resolution at the June, 1976 Annual Meeting of the American Medical Association directing the AMA to immediately conduct a membership opinion survey that asks the following two questions:

1. Are you in favor of the enactment of a National Health Insurance program in this country?

2. Do you believe the American Medical Association should sponsor a National Health Insurance proposal?

and be it further

RESOLVED, that this resolution also state that if the results of this survey reveal that the physicians of this country oppose National Health Insurance and AMA's sponsorship of an NHI plan, the American Medical Association immediately withdraw its NHI legislation (H.R. 6222—Comprehensive Health Care Insurance Act of 1975), and be it further

RESOLVED, that each state medical association scheduled to meet prior to the AMA Annual Meeting be urged to take a similar position on National Health Insurance and instruct its AMA delegates to support the Georgia resolution.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends adoption of Resolution 12-76 and adds to the report for information, a copy of a letter from Dr. James H. Sammons, of the American Medical Association, to the Louisiana State Medical Society:

March 17, 1976

F. Michael Smith, Jr., M.D.
President, Louisiana State Medical Society

Dear Dr. Smith:
Your recent proposal to publish a questionnaire as an

advertisement in American Medical News was reviewed by the Board of Trustees during its March 11-13 meeting. We have traditionally not accepted questionnaires from outside organizations for inclusion in our publications in any form, and the Board agreed that this practice should be continued.

In reaching this decision, the Board was cognizant of the fact that AM News and our other publications are distributed to non-member physicians, non-physicians, libraries, and other institutions. Responses from the sources might not be easily identifiable and might distort the survey results. The AMA has largely discontinued the distribution of its own questionnaires through our publications for this reason.

The Board also recognized that the inclusion of a questionnaire of this type in one of AMA's publications might give the impression that it was an activity of ours or one that carried our endorsement, regardless of the manner in which it was presented.

In summary, we cannot accept your proposed advertisement for our publication. Please let me know if I can be of assistance to you in any other way.

Sincerely,
James H. Sammons

HOUSE OF DELEGATES ACTION—Adopted Resolution 12-76.

RESOLUTION 15-76
DHR-MEDICAID CONTROLLED MEDICAL ASSISTANCE DRUG LIST

Robert P. Coggins, M.D., Delegate
Cobb County Medical Society

WHEREAS, the primary purpose of the DHR-Medicaid Controlled Medical Assistance Drug list as presently being considered by a committee of physicians and pharmacists of the State of Georgia is to supposedly reduce the drug costs under the Medicaid program, and

WHEREAS, such a drug list is unworkable for all involved on a practical, practicing basis, and

WHEREAS, this is another incidence of government invasion into the private practice of medicine, now therefore be it

RESOLVED, that the Medical Association of Georgia go on record in opposition to the proposed adoption of such a restrictive drug list.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee recommends adoption of Resolution 15-76, DHR-Medicaid Controlled Medical Assistance Drug List and further recommends that copies of this resolution be transmitted to the MAG Liaison Committee to the Board of Human Resources, and to the members of the Board of Human Resources.

Your Reference Committee discussed at length information pertaining to the proposed cost savings, and from testimony given your Committee, we unanimously felt at this time a restrictive drug formulary would not result in a significant cost saving while at the same time could conceivably result in poor quality of medical care.

HOUSE OF DELEGATES ACTION—Adopted Resolution 15-76.

REFERENCE COMMITTEE D

RESOLUTION 16-76
BALANCED FEDERAL BUDGET

Robert Simmons, M.D., Delegate
Whitfield-Murray County Medical Society

WHEREAS, the United States of America is facing a need for increased fiscal responsibility, and

WHEREAS, it is recognized that payments on the interest for the national debt represent a large and growing portion of the current Federal expenditure, and

WHEREAS, the Honorable Senators Sam Nunn and Herman Talmadge of Georgia have introduced an amendment to the Constitution of the United States of America into the Congress, and

WHEREAS, said constitutional amendment would require that the United States of America be balanced except in times of national emergency, and

WHEREAS, this approach to fiscal responsibility is recognized as vital to the continued well-being of our country, now therefore be it

RESOLVED, that the Medical Association of Georgia does support the constitutional amendment as proposed by Senators Nunn and Talmadge and urge its adoption.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your Reference Committee reviewed with interest and concern Resolution 16-76, Balanced Federal Budget. We were in sympathy with the intent of this Resolution. Your Reference Committee recommends that this Resolution be received for information since this was not directly related to health care. Your Reference Committee does, however, urge every MAG member as an individual citizen of the United States to support Senators Talmadge and Nunn in their efforts to balance the federal budget.

HOUSE OF DELEGATES ACTION—Received Resolution 16-76 for information only.

Chairman McDonald expressed his appreciation to the members of the Reference Committee and the MAG staff for their time and effort in the preparation of this report.

REPORT OF REFERENCE COMMITTEE D

JACK F. MENENDEZ, M.D., CHAIRMAN

Chairman Menendez reported to the House of Delegates that the reports and resolutions referred to Reference Committee D had been considered by the Reference Committee which met at 2 p.m. in Colony Hall, Holiday Inn, Jekyll Island, Georgia, on April 9, 1976. Members of the Committee present included Jack F. Menendez, M.D., Macon, Chairman; Louis H. Felder, M.D., Vice Chairman; Daniel R. Luke, M.D.; R. J. Moye, M.D.; and Joseph M. Almand, M.D.

SUPPLEMENTAL REPORT OF COMMITTEE ON CANCER

Hoke Wammock, M.D.

Realizing that cancer prevention can be furthered by discouraging smoking and encouraging proper diet, and feeling that it is a responsibility of the Medical Association of Georgia to encourage action to protect the health of the public, the following recommendation is made.

RECOMMENDATION

That MAG actively support legislation to: 1) prohibit smoking in hospitals, and; 2) require that appropriate education programs on nutrition be introduced in the primary grades of public schools.

REFERENCE COMMITTEE RECOMMENDATION —The report calls upon MAG to help in the prevention of cancer by discouraging smoking and encouraging proper diet. While your Reference Committee is in agreement with these objectives, after listening to testimony, it recommends that the first recommendation concerning MAG support of legislation to prohibit smoking in hospitals be not approved, since this would put undue burdens on physicians, hospital employees and patients. The second recommendation is that the MAG support legislation to require education programs on nutrition in public schools. Your Reference Committee recommends that this recommendation be approved with the following change: "That the MAG actively support legislation to encourage education programs on nutrition at a time in public school curricula when further education seems advisable."

HOUSE OF DELEGATES ACTION—The House voted to not approve recommendation 1 of the Cancer Committee's Report and adopted the 2nd recommendation as amended by the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

J. Gary Palmer, M.D.

The committee fulfilled its charge by the 1975 House of Delegates to inform the physicians of Georgia and the public of the venereal disease problem in the state.

1. Five television and radio public service spots were made and distributed to all the stations in Georgia. The responses from the stations have indicated that the material was reasonably well accepted and the spots were used.

2. A semi-permanent card was prepared outlining the suggested treatment schedules for syphilis and gonorrhea. These cards were distributed to all Georgia physicians along with a brochure reminding the doctor that he is required by law to report cases of V.D. to the local health department.

The committee has held two meetings during this last year. Both meetings concerned themselves with defining the proper role of the Committee on Public Health. It was pointed out that the committee was created primarily to come to grips with the increasing V.D. problem. With this project completed the Committee questions whether or not they should "look for" another "problem" to investigate. The Committee considered a project designed to increase the immunization levels of pre-school children but information received



The question of membership in MAG for osteopathic physicians is reviewed by Reference Committee D, whose chairman is Jack F. Menendez of Macon. Ronald F. Galloway, Vice Speaker of the House, presides from the podium.

from the state epidemiologist indicated that the level is now rather good and the cost/benefit would be very low in an all-out campaign with mass screening and immunizations similar to the polio campaigns in recent years. The Committee did agree to work with DHR in their limited campaign held every year in the late spring.

This committee ultimately is concerned as to whether or not there is indeed a truly separate function to justify its existence. It is noted that a Subcommittee on Public Education of the Committee on Education has been established to undertake the task of keeping the public aware of health problems. The Committee thus concludes that unless the House of Delegates creates a new charge for the Committee on Public Health, it must:

Recommend that the Committee on Public Health be dissolved as a Special Committee and reinstated as an Ad Hoc Committee when a specific task for it arises.

REFERENCE COMMITTEE RECOMMENDATION —The report describes the committee's work in educating the public about venereal disease and concludes with the recommendation that the committee be dissolved as a special committee and reinstated as an ad hoc committee when a specific task for it arises. Your Reference Committee heard testimony to the effect that the Committee on Public Health had completed its work in the area of V.D. education, but it was pointed out that a new subject for study appropriate to the committee has recently arisen. This is the matter of the swine influenza immunization program approved by President Ford. Your Reference Committee therefore recommends that the recommendation be not approved and wishes to recommend further that the committee's present status as a special committee will allow it to study the swine influenza immunization program in a consultative role to the Department of Human Resources.

HOUSE OF DELEGATES ACTION—Voted to not approve the recommendation of the Committee which calls for the dissolution of the Committee on Public

Health, and adopted instead the recommendation of the Reference Committee which calls for an active role for the Public Health Committee in the Swine Influenza Immunization Program.

COMMITTEE ON COMMUNICATIONS

(Recommendation 1)

Marvyn D. Cohen, M.D.

(For the full text of the report of the Committee on Communications, see the report referred to Reference Committee A.)

RECOMMENDATION

1. That responsibility for the residents workshop be assumed by the Assistant Director for Education after the 1976 seminar.

REFERENCE COMMITTEE RECOMMENDATION —As directed, your Reference Committee considered only the part of this report which describes the practice management workshops sponsored by the MAG for senior residents. The recommendation relating to this activity is that the responsibility for directing these workshops be transferred to the Assistant Executive Director for Education after the 1976 seminar. Your Reference Committee heard testimony to the effect that the directing of these workshops is more properly the work of MAG's Assistant Executive Director for Education than of the Committee on Communications. Therefore, your Reference Committee recommends that recommendation 1 of the Report of the Committee on Communications be approved.

HOUSE OF DELEGATES ACTION—Adopted recommendation 1 of the Committee on Communications.

RESOLUTION 7-76 CRAWFORD W. LONG MUSEUM

Thomas L. Tidmore, Jr., M.D., for Medical Association of Atlanta

WHEREAS, Crawford W. Long was the first to utilize ether for surgical operation, and this was probably one of the greatest and most profound medical discoveries made in the United States, and certainly in the South, and

WHEREAS, the museum dedicated to him and initiated by the Medical Association of Georgia and the State of Georgia at Jefferson, Georgia, is in dire need of funds to continue fostering this information and making available their exhibits for public viewing, and

WHEREAS, the federal government has withdrawn federal funds from the support of the museum,

NOW, THEREFORE, BE IT RESOLVED: (1) That continued support be made available from the Medical Association of Georgia; and (2) that efforts be expended by our Association to obtain financial support from other groups and from physicians in the South; and (3) that support from the physicians in our Association be made more convenient by listing a donation on our dues statement each year as "Contribution to the Crawford W. Long Museum Association—$10.00."

REFERENCE COMMITTEE RECOMMENDATION —The resolution describes the Crawford W. Long Museum at Jefferson, Georgia, and explains the need for funds to continue this museum. The resolution calls for continued financial support by the MAG, that the MAG solicit support from other groups, and that support from MAG physicians be made more convenient by listing a donation for the museum on the annual dues statement as an option. Testimony before the Committee brought out the feeling that MAG members were in favor of supporting the museum and your Reference Committee therefore recommends that the resolution be approved in full. Your Reference Committee wishes to add the recommendation that continued MAG financial support be made contingent upon budget availability.

HOUSE OF DELEGATES ACTION—Adopted Resolution 7-76 with the additional recommendation that continued MAG financial support be made contingent upon budget availability.

REFERENCE COMMITTEE D

COMMITTEE ON NURSING

John P. Wilson, M.D.

MAG's Committee on Nursing is composed of five physicians who also serve as the physician members of the Joint Practice Committee for Georgia, a committee composed of an equal number of representatives from the MAG and the Georgia Nurses Association.

The Joint Practice Committee met once during the past year and took up several issues relating to the training and practice of nurses:

1. Two year or Associate Degree Nursing Programs: The committee notes the rapid growth of such training programs in Georgia and is concerned about an apparent lack of adequate clinical training on the part of some of the graduates of these programs. Together with the Georgia Hospital Association and the new state Board of Nursing, the committee will continue to work on the formulation of criteria for the clinical segment of the two-year nursing curricula.

2. Extended Role Nursing: The utilization of nurses who have an extended practice, such as nurse practitioners and nurse midwives, is becoming more common in Georgia. There is concern that the practice of these nurses is not regulated by the kind of safeguards and controls built into such parallel professions as physician assistant. The committee is actively engaged in drawing up guidelines to define the scope of practice of the various specialties within extended role nursing.

3. Administration of Blood Transfusions by Nurses: In response to a general concern about who is qualified to administer blood transfusions and intravenous solutions, the committee is engaged in drawing up a policy statement of the two professions of medicine and nursing which gives guidelines for these procedures.

The committee is active in the National Joint Practice Commission and sent two of its members (a physician-nurse team) to the Second National Conference on Joint Practice in November, 1975.

REFERENCE COMMITTEE RECOMMENDATION —The report describes the work of the Committee on Nursing and of the Joint Practice Committee for Georgia and contains no recommendation. However, Council's comments on the report warned of the danger

of allowing nursing practice to go beyond the control of physicians, and the report was therefore referred to Reference Committee D. Your Reference Committee considered the report in depth and recommends that it be accepted for information along with the comments of Council. After hearing considerable testimony on nursing practice, the committee came to the conclusion that the subjects treated in the report have critical long-term implications and should be considered as an area of continued interest on the part of MAG. Your Reference Committee wishes to make its own recommendation that the physician members of the Joint Practice Committee in their committee work should scrutinize the scope of practice of the various specialties within the extended role of nursing.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee as amended by Reference Committee to provide that the physician members of the Joint Practice Committee in their work scrutinize the scope of practice of the various specialties within the extended role of nursing.

OSTEOPATHY

The following three items related to osteopathy were considered together by the Reference Committee. The Reference Committee recommendation and subsequent House action which follows relates to these three items as a whole.

SECRETARY MEMBERSHIP FOR OSTEOPATHIC PHYSICIANS

Earnest C. Atkins, M.D.

RECOMMENDATION

Change the Constitution and Bylaws to allow osteopathic physicians to have full membership in the MAG. There is pressure to give these physicians seats on committees, panels and boards, such as the GMCF. If they are allowed full membership, special dispensations would not be necessary, and it would be their responsibility to accept MAG membership with all its privileges or to reject it and not expect special consideration.

If this recommendation is adopted, it will also increase MAG membership.

RESOLUTION 9-76 MEMBERSHIP FOR OSTEOPATHIC PHYSICIANS

James Kibler, M.D., for Laurens County Medical Society

WHEREAS there are those of us who are interested in maintaining our patient's highest confidence and trust built upon a traditional code of ethics which has taken years to establish.

WHEREAS, we feel that persons not trained in a bona fide school of medicine should not be entitled to inherit this code of ethics by automatically being given the title of medical doctor along with its traditional rights and privileges.

WHEREAS, we feel that a dangerous precedent was set in the State of Georgia when the federal courts ruled that a doctor of osteopathy could not be denied a license with the designation of "M.D." so long as licenses with the designation "M.D." were granted to foreign-trained physicians who did not have an M.D. degree, thus allowing a person to assume the title of doctor of medicine without having graduated from a school which grants M.D. degrees.

WHEREAS, we fear that a natural development of this line of reasoning may allow others in allied medical fields to follow a similar course of action.

WHEREAS, we are aware of our deficiencies in having our code of ethics adhered to among members of our own profession with its attendant problems in the areas of malpractice and public relations.

WHEREAS, we do not wish to see the Medical Association of Georgia become a party to this development thus undermining the very foundation upon which our profession stands, therefore, be it

RESOLVED, that doctors of osteopathy not be recognized as doctors of medicine by being granted membership in the Medical Association of Georgia; and, be it further

RESOLVED, that the Medical Association of Georgia urge the Composite State Board of Medical Examiners to appeal the ruling of the "Oliver vs. Composite State Board of Medical Examiners" case, bearing in mind that the board grants licenses and not degrees.

COMMITTEE ON OSTEOPATHIC LIAISON

Wytch Stubbs, M.D.

The Osteopathic Relations Committee met on September 16, 1975, to consider the question of representation by the Georgia Osteopathic Medical Association on the Board of the Georgia Medical Care Foundation. The Committee recommended that:

WHEREAS, doctors of osteopathy are a licensed body of physicians in the state of Georgia, and

WHEREAS, they represent a special discipline of acceptable training and

WHEREAS, they serve a sizeable segment of the population of Georgia, and

WHEREAS, they operate a fully accredited hospital in the state of Georgia, and

WHEREAS, they, along with doctors of medicine, are the only disciplines recognized for medical care by the armed forces and the Veterans Administration,

The Georgia Osteopathic Medical Association should be represented on the Georgia Medical Care Foundation with a member and alternate member on the Board of Directors of the Foundation.

At the time of this report's preparation, proposed bylaw changes which would incorporate the above recommendations had been passed by the Board of Directors of the Georgia Medical Care Foundation and had been presented for a first reading before the MAG Council. The second reading is scheduled for March.

REFERENCE COMMITTEE RECOMMENDATION —Three documents relating to osteopaths were referred to the Reference Committee and the committee considered them together. A recommendation from the Secretary of MAG called upon MAG to change the Constitution and Bylaws to allow osteopaths membership in the MAG. On the other side of the issue, a resolution, presented by Dr. James Kibler, from the Laurens County Medical Society recommended that osteo-

paths not be granted membership in the MAG, and furthermore that the MAG urge the Composite State Board of Medical Examiners to appeal the ruling in the "Oliver vs. Composite State Board of Medical Examiners" case in which the Federal Courts ruled that osteopaths could not be denied a license with the designation of M.D. so long as licenses with the designation of M.D. are granted to foreign trained physicians who do not have an M.D. degree. The Reference Committee heard considerable testimony on the issue of accepting osteopaths into the MAG, and this testimony revolved principally around two issues: (1) the osteopaths themselves, and (2) the use of the "M.D." title for foreign medical graduates. In view of the overwhelming sentiment against accepting osteopaths into the MAG on the part of those giving testimony, Reference Committee D recommends that the recommendation of the Secretary be not approved and that the resolution of the Laurens County Medical Society be approved but with deletion of the second part of the resolution calling upon MAG to urge appeal of the Oliver case. Your Reference Committee makes its recommendation upon testimony that osteopaths have not elected to become members of other state medical associations when given the opportunity. The bulk of testimony indicated that whereas osteopaths may be granted a "Doctor of Medicine" title by the Composite State Board of Medical Examiners, the level of care given by osteopaths may be less than that expected of those holding membership in the MAG. MAG's counsel, Mr. Winston Huff, spoke to the question raised in the last part of the Laurens County Medical Society resolution, that of urging appeal of the Oliver case. Mr. Huff explained that the period for appeal of this decision had long passed, and your Reference Committee therefore recommends deletion of this part of the resolution. Discussion at the Reference Committee considered determining what title is most appropriate for foreign medical graduates who did not receive an "M.D." degree. The testimony of several foreign medical graduates on the significance of using the "M.D." title indicates that further study should be given to the matter. Your Reference Committee therefore recommends that the matter of use of the "M.D." designation be referred through Council to the Committee on Legislation for further study and appropriate legislative action.

Your Reference Committee also considered the annual report of the Committee on Osteopathic Liaison which contains the recommendation that the Georgia Osteopathic Medical Association be represented on the Georgia Medical Care Foundation, with a member and alternate member on the Board of Directors of the Foundation. The Reference Committee heard testimony to the effect that since the Georgia Medical Care Foundation's Board of Directors is providing peer review for all medical care in the state and is not a private organization like the MAG, it is appropriate that osteopaths be represented on the Board to provide peer review for the osteopaths in Georgia providing medical care. Your Reference Committee therefore recommends that the report of the Committee on Osteopathic Liaison be approved along with its recommendation.

Therefore, in summary, Mr. Speaker, your Reference Committee recommends: (1) disapproval of the recommendation contained in the Report of the Secretary regarding acceptance of osteopaths for membership in the MAG. (2) Approval of the Resolution of the Laurens County Medical Society on the same subject but with deletion of the second portion of the resolution calling upon the MAG to appeal the Oliver decision. (3) that the matter of the use of the "M.D." (4) approval of Osteopathic Liaison Committee Report and its recommendation.

HOUSE OF DELEGATES ACTION—Disapproved the recommendation of the Secretary which calls for a Constitution and Bylaws Amendment to allow osteopaths full membership in MAG; adopted Resolution 9-76 with the second resolve deleted; adopted a recommendation made by the Reference Committee that "the matter of the use of the M.D. designation be referred through Council to the Committee on Legislation for further study and appropriate legislative action"; and did not approve the report of the Committee on Osteopathic Liaison.

REFERENCE COMMITTEE D

AD HOC COMMITTEE ON PHYSICIAN'S ASSISTANTS

John P. Wilson, M.D.

The 1974 MAG House of Delegates brought this committee into being for the express purpose of investigating the new allied health field of physician's assistants. The committee was to report back its findings to the 1975 House of Delegates. However, the committee needed more time to complete its study, and the report has been delayed to the present session of the House of Delegates.

The committee met four times and discussed a variety of issues related to the definition, training, utilization, and regulation of PAs. There follows the committee's final report, which is in the form of a position statement. With this report the committee considers its charge accomplished.

Physician's Assistants in Georgia: A Position Statement

The allied health profession of physician's assistant (PA) is barely a decade old in this country, and the utilization and certification of PAs in Georgia is a phenomenon principally of the last five years. According to the records of the Composite State Board of Medical Examiners, there were in early 1976 approximately 275 certified PAs in Georgia. Of these, 107 are graduates of training programs approved by the AMA.

Definition: The Physician's Assistant is a skilled person, qualified by academic and practical training, who, under the supervision of a responsible licensed physician, can collect and organize historical and physical data and present them so that the physician can visualize the medical problem and determine appropriate diagnostic and therapeutic steps. He is also capable of assisting the physician by educating patients, by performing diagnostic and therapeutic procedures, and by coordinating the roles of other health care assistants. The PA is distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

Relation between the Physician and PA: In the state of Georgia every PA must be employed and supervised by a physician. Whether a PA is utilized appropriately and ethically will depend to a large extent upon the re-

sponsibility and integrity of the employing physician. It is apparent that if the PA is to fulfill his proper role in a variety of settings, the ultimate responsibility must rely on the judgment of the sponsoring physician, and while the approving board may specify the activities of a given PA, we would re-emphasize the basic element of the assigned physician's responsibility for that PA. For this reason, we would emphasize that the acceptability of the concept of the PA and the fundamental issues involved is predicated on the moral and ethical responsibility of the PA.

Since discipline of the physicians is beyond the province of this committee, all considerations regarding PAs must be based on the assumption that the Medical Association of Georgia and the Composite State Board are willing to assume the ethical, moral, and professional competency of any physician utilizing PAs, and must be willing to impose disciplinary measures on physicians who misuse PAs, even more stringently than a breach of other professional responsibilities.

Appropriate Tasks: The appropriate tasks of the PA should be treated within the context of the original concept of the PA as a "physician extender." The duties of the PA will be based on the extent of his formal training, on the training under his supervising physician, and on his skills which augment the physician's ability to provide proper medical care to his patients.

The type of practice, the location, and the PA's responsibilities and tasks should be delineated in his job description, which cannot be standardized, since it will vary with each PA. It is felt there is still a need to differentiate more clearly between PAs, technicians, and nurses who act in the role of physician extenders.

The training and job description delineated in the application for certification should be carefully scrutinized, along with the qualifications of the sponsoring physician. Only those portions of the job description should be approved which hold promise of offering the best health care to the most people while at the same time minimizing unnecessary risks.

Education: A PA should be a graduate of a PA training program approved by the AMA. There are over 60 approved programs in the United States, with three being located in Georgia. Most programs approximate 24 months in length and offer college degrees on successful completion. Graduates are eligible to sit for a national certification examination developed by the National Board of Medical Examiners and administered by the National Commission for Certification of Physician Assistants. This examination is designed to assess the PA's knowledge and competency in applying that knowledge to clinical problems and conditions prevalent in the primary health care setting.

In order to maintain relevant curricula, educational institutions offering PA training programs should be guided by information provided by physicians who employ PAs.

The PA, once graduated, should maintain the level of his knowledge and practice by participating regularly in continuing education activities.

Regulation: The Physician's Assistant Act of Georgia, together with the rules added to the Act, provide legal safeguards for the utilization of the PA. Certification of the PA may be either permanent or temporary, and permanent certified PAs must be graduates of approved PA training programs. Although the passing of an examination is not presently required for certification, the Federation of State Medical Boards has recently recommended it.

Conclusion: Provided that the physician extender is properly trained and responsibly utilized by the employing physician, there is a definite place for him within Georgia's system of health care.

REVIEW OF THE ANNUAL REPORT OF THE COMMITTEE TO STUDY PHYSICIAN'S ASSISTANTS

Milton I. Johnson, M.D., Councilor, Bibb County

Report to Fleming L. Jolley, M.D., Chairman, MAG Council

In accordance with your assignment authorized by Chapter 11, Section 1 of the Medical Association of Georgia Bylaws which states that Council shall review all Committee Reports and has authority to make recommendations to the House of Delegates on the reports, I have reviewed the above Annual Committee Report. After careful study of this report, the following comments are submitted for consideration by MAG Council:

The entire concept of a "Physician's Assistant" is at best, dubious indeed. At the risk of seeming somewhat paranoid, I will state at the outset that it is my feeling that the Physician's Assistant Program is basically a move by the federal government to undermine and thus make it more easily to subdue the medical profession in its insatiable obsession to destroy quality medical care in America under the guise of improving same. In my opinion, there would be few if any physician's assistant programs extant in this country were it not for the fact that all are dependent upon their existence upon federal grants. Thus it is the federal government that is interested in physician's assistants, and not the physicians themselves, as a general rule. Furthermore, the federal government has already stated in print that there will be a large surplus of physicians by the 1980's.

So disinterested is the average physician that many of the graduates have not been able to find jobs in private medical offices, but, as I understand it, most are employed doing ancillary work in hospitals. It is interesting to note that the University of Alabama discontinued its Physician's Assistant Program within the last few months because it found that there were few jobs available in the State of Alabama for these people.

I would respectfully call to your attention an interesting corollary that took place in two other professions and the result of same over the past few decades. You may recall that 30-40 years ago the profession of pharmacy was in a state of disarray. There were no real qualifications to be a pharmacist other than proof that one had worked in a drug store for a prescribed number of years and passing a written examination administered by the State Board of Pharmacy. The pharmacists themselves, in an effort to up-grade their profession, first made mandatory attendance at a two-year college of pharmacy a prerequisite for taking the state board examination. In 1933 this was increased to four years of formal education requirement prior to taking the State Board Examination, and, several years ago, the educational requirements were increased to five years plus a year of documented internship to be granted a full license to practice in the State of Georgia.

The nursing profession, on the other hand, took the very opposite tack. One of the main reasons why the nursing profession is not able to achieve much professional recognition except amongst themselves is the fact that they have fragmented themselves into so many subdivisions that it is difficult to decide exactly what a nurse really is. At this time in the State of Georgia there are licensed practical nurses, two-year college graduate RN's, licensed undergraduate nurses, three-year diploma school graduates, bachelor degree holders, master's degree holders, and Ph.D. nurses. Until the nursing profession decides just what a nurse is and should be, they will neither receive much professional recognition outside their own profession, nor proper remuneration for their efforts.

Conversely, the quality of men and women practicing pharmacy and their remuneration has risen markedly over the years.

It follows from these examples that a person should either be a physician or not be a physician, and not be a half physician or quarter physician or three-quarters physician.

Thus, the physician's assistant is, in large measure, not needed either on a theoretical or on a practical basis in the State of Georgia. Furthermore, it is not fair to train these young people in a pseudo-profession with the full knowledge within the next eight or nine years there will be no place for them to make a living in the medical field.

You may be sure, that though they are under the control of the Composite Board of State Medical Examiners at this time, when their livelihood is threatened, they will seek to set up independent state board of examiners for their "profession." When this comes to pass, the physicians of Georgia will be told by the physician's assistants just exactly what the physician's assistants are going to do and there will be no way that they can control what they do.

I am informed by our distinguished Councilor from Muscogee County, Dr. Jack Raines, that there is a bill now in the Tennessee legislature to license physician's assistants independently. As you no doubt are aware, they already have a national organization which is pressing for this type of legislation.

It is easy to see that a physician's assistant, usually a young man full of idealism and zeal and anxious to achieve professional recognition may easily find duties and responsibilities foisted upon him by certain physicians who choose to operate a so-called "machine" type of practice. Certainly, physician's assistants have the potential of generating revenue far beyond their salary if used in a perverted manner.

The question follows, is it ethical to charge patients for first class medical care when it is being rendered by a second class practitioner? Those few people who are using physician's assistants in private practice and those who are not may soon find that, under federal medical programs, rules will promulgate which will adversely affect their financial situation.

As an example, suppose a physician has a patient who comes to his office and is found to have hypertension. The physician does a history and quality physical examination and procures the necessary lab work and writes the necessary prescriptions. After a visit or two, the patient's blood pressure is well controlled. Under these federal programs, it is easy to see that the cookbook protocol will state that the patient no longer needs to be seen by the physician himself but can be seen by the physician's assistant. Since a physician is not seeing the patient, the proscribed fee will probably drop to somewhere in the neighborhood of 50 percent of the physician's usual charge. Those physicians who refuse to hire a physician's assistant may be shocked to find that they have been declared to be their *own* physician's assistant for purposes of remuneration. Thus the physician would be squeezed to participate in his own demise. The poor patient is caught in the middle and winds up with half way medical care by a half way physician paid for with half standard fees.

Doctor, is this the type of medical care that you wish to see ultimately inflicted on your patients?

The conclusion of this committee report states that "provided the physician's extender is properly trained and responsibly utilized by the employing physician, there is a definite place for him within the Georgia system of health care."

I submit to you gentlemen there is no *immediate* place for physician's assistants in the system of quality medical care and time will prove that there is no *long-term* place for him in any system of medical care because of the situations outlined above.

It is my sincere recommendation that the MAG Council recommend to the House of Delegates that the House recommend the immediate termination of all physician's assistant training programs in the State of Georgia and that our MAG delegation present a resolution to the American Medical Association calling for the immediate termination of all physician's assistant programs.

Respectfully submitted,
Milton I. Johnson, M.D.

REFERENCE COMMITTEE D

REFERENCE COMMITTEE RECOMMENDATION —This report, which includes a position statement on physician's assistants in Georgia, contains no recommendation and was not originally referred to a Reference Committee. However, at April 8 Council meeting issue was taken with a number of statements contained in the report, and the report, together with Dr. Milton Johnson's critique, was therefore referred to Reference Committee D. Testimony in Reference Committee was long and heated, and opposing views were presented on practically every aspect of the issue of physician's assistants. The discussion of PAs focused on three areas: the ideal utilization of PAs by responsible employing physicians; the abuses of PAs under physicians who do not assume proper responsibility for them; and the long-term philosophical discussion of the place for the PA in the health care delivery system 5-10 years from now when there might be a surplus of physicians.

After carefully considering the testimony, your Reference Committee recommends that the Report of the Ad Hoc Committee on Physician's Assistants be received for information along with Dr. Johnson's critique referred by Council.

Your Reference Committee further observes that the report of the Ad Hoc Committee on Physician's Assistants did not address itself to certain problems brought up in the discussion before the Reference Committee. These problems include: (1) the attempt

of PAs to become independently licensed; (2) increasing government utilization of PAs in lieu of physicians; (3) the push by national PA organizations for greater autonomy for PAs; and (4) the growing surplus of physicians which in the future might result in a confrontation between physicians and PAs concerning the role of PAs in health care.

Therefore, your reference committee recommends that MAG look into both actual and potential problems which exist in the development of the PA profession and further urges that all MAG members who wish to testify on these matters be encouraged to come before the PA Committee to do so.

HOUSE OF DELEGATES ACTION—Received the report of the Ad Hoc Committee on Physician's Assistants together with a critique presented to the Reference Committee by Dr. Milton Johnson for information. The House further adopted a recommendation made by the Reference Committee which provides "that MAG look into both actual and potential problems which exist in the development of the PA profession and further urges that all MAG members who wish to testify on these matters be encouraged to come before the PA Committee to do so."

COMMITTEE ON ANNUAL SCIENTIFIC ASSEMBLY

LaMar S. McGinnis, M.D.

At its 1975 spring meeting, MAG's House of Delegates gave approval and financial support to the first independent annual MAG Scientific Assembly. In addition, it stipulated that the continuance of an annual fall scientific meeting be based upon an evaluation of the success of the 1975 meeting. The Scientific Assembly was held on November 21-22, 1975, at the Terrace Garden Inn in Atlanta. There follows an evaluation of the meeting.

FORMAT

The 1975 Scientific Assembly was conceived primarily as a forum for the individual state specialty societies (i.e., those represented on MAG's Interspecialty Council) to put on their own scientific programs. MAG furnished the meeting room space, audio-visual equipment, funds for speakers, publicity, and printing. Twelve specialty societies participated in the 1975 Assembly, with individual scientific programs ranging from two hours to three half-days.

In addition to the scientific programs of the specialty societies, the MAG sponsored an opening luncheon and an educational program for spouses. The luncheon featured the Abner W. Calhoun Lecture, which was delivered by Professor Anne R. Somers of the College of Medicine and Dentistry of New Jersey. Mrs. Somers' talk on consumer health education was well-received and provided a theme for several of the scientific programs. The spouses' program featured a discussion of special problems in the doctor's family and an educational tour of the arts. Judging by the comments of those in attendance, the Planning Committee believes that such a format is ideal for the Scientific Assembly.

ATTENDANCE

The turnout for the 1975 Scientific Assembly was beyond expectations, with 403 persons registered and an estimated total attendance of almost 500. Included in the registration figure are program speakers and a number of interns, residents, and physicians' spouses. The number of registered attendees at individual scientific programs ranged from 11 to 97. It is of interest to note that 344 of those registered are members of the MAG and that 176 are from outside of the Atlanta area (with 10 from outside the state).

FINANCING

The amount budgeted for the Assembly was $9,701. Actual expenditures were $11,061.70. Since the registration receipts totalled $4,752.00, the cost of the meeting to the MAG was $6,309.70. Included in expenditures was $4,632.32 for speakers in the various specialty programs. The Planning Committee views these speakers' funds as essential to the participation of the specialty groups in the Scientific Assembly. The speakers secured through the funds add to the quality of the continuing education which takes place. This year there were 13 out-of-state speakers and numerous speakers from within the state.

FUTURE PLANS

Contingent upon approval of MAG's House of Delegates, the Planning Committee has set aside the dates of November 19-20 for the 1976 Scientific Assembly. The new Omni International Hotel in Atlanta has been reserved as the meeting site. The format for the meeting will be the same as that for the 1975 Assembly.

AREAS OF CONSIDERATION

With the 1975 Scientific Assembly the MAG has made an excellent start in sponsoring continuing medical education programs. We hope this annual meeting will become a tradition recognized for its quality and participated in by physicians of every specialty.

If a tradition of quality is to be established, several important questions must be addressed by the Planning Committee and the House of Delegates: Should the MAG continue to serve as the umbrella under which the autonomous specialty groups plan and execute their own programs? How should the meeting be financed? Should we expand the scope of the meeting by offering true postgraduate education with formal courses. syllabus, and faculty? Should MAG's Director of Education have an administrative assistant to help him with the demanding and time-consuming work of coordinating the Scientific Assembly? Should the MAG seek the cooperation of the Atlanta Graduate Medical Assembly for the purpose of offering expanded educational meetings in both the fall and the spring on an annual basis?

RECOMMENDATIONS

In line with this report the Planning Committee makes the following recommendations:

1. The MAG should continue to sponsor an annual Scientific Assembly, furnishing the necessary financial support.
2. The MAG should continue to reimburse specialty societies for a portion of the expenses they incur in obtaining speakers for their programs at the Assembly.
3. A portion of MAG dues income should be set aside every year to cover the cost of the Assembly. MAG members should be informed that this educational meeting is one of the benefits of membership.

4. An administrative assistant should be hired to help MAG's Director of Education coordinate the Assembly. This would be a part-time position.

5. To insure both continuity and an influx of fresh ideas on the Planning Committee, a new person should be appointed each year to serve on the Planning Committee, and a new chairman for each Assembly should be selected from within the committee.

6. Beginning in 1976, the Scientific Assembly should be expanded to two full days.

7. The MAG should apply to the AMA for accreditation of all its continuing education programs, especially the Scientific Assembly.

8. The MAG should apply to the American Academy of the Family Physicians for accreditation of the Scientific Assembly.

ADDENDUM A
Study of Scientific Assembly Data

Breakdown of attendance into specialty groups:

Registered		*Estimated*
97	ACP, Georgia	100
46	ACS, Georgia	50
13	Georgia Neurological Society	20
41	Georgia Radiological Society	60
17	Georgia Association of Pathologists	20
22	Georgia Society of Plastic Surgeons	40
41	Georgia Thoracic Society & American College of Chest Physicians	60
11	Georgia Gastroenterologic Society	42
12	Georgia Neurosurgical Society	20
47	Georgia Society of Ophthalmology	56
35	Specialty Meeting Unknown	
21	Spouses Program	30
403	TOTAL	498

(This total includes 21 interns and residents)

Total number paying registration fee: 340; Gross receipts: $5,976.00 (MAG: $4,752, ACP: $1,050, GSIM: $168, Luncheon); Unpaid fees: $300.75.

Breakdown of registration according to MAG membership: MAG members, 344; non-members, 38; spouses, 21. Opening Luncheon: 155; number of hotel guest rooms occupied: 131.

Demographic Breakdown: Atlanta, 206; Augusta, 19; Savannah, 19; Macon, 14; Albany, 7; LaGrange, 10; Gainesville, 8; Columbus, 8; Athens, 7; North Georgia, smaller towns, 32; South Georgia, smaller towns, 42; out-of-state, 10.

EXPENDITURES

(Does not include expenses for specialty group speakers)

Honoraria:	
Anne Somers	$ 200.00
Dr. Messer	200.00
Rev. Bowers	15.00
Travel Expenses:	
Anne Somers	280.64
Printing:	
Flyers (4,300)	129.30
Program Brochures (5,700)	1,346.80
Registration and Evaluation Forms	114.40
Name Cards (Luncheon)	3.20
Tickets for Luncheons	62.40
Mailing:	
Flyers: Stuffing, Addressing	127.83
Flyers: All-Member Mailing Postage	426.00
Programs: Stuffing, Addressing	122.78
Decorating:	
Signs	262.08
Registration:	
Badges	75.45
Typewriter Rental	31.20
Educational Tour:	
Spouses Tour of Arts and Luncheon	437.50
Audiovisual:	
Equipment and Operators	1,162.37
Hotel:	
Luncheon (155)	787.86
Coffee Breaks (2 for 150)	179.40
Hospitality Suite	141.00
Gratuities for Hotel Staff	95.00
Telephone	2.25
Staff:	
Clerical (Overtime at Registration)	199.31
Lunch	27.61
TOTAL	$6,429.38
EXPENSES PAID FROM OTHER FUNDS:	
Calhoun Lecture Fund, Talk by Mrs. Somers	300.00
Communications Committee, 1 All-Member Mailing Postage	426.00
TOTAL	$ 726.00
GRAND TOTAL	$7,155.38

EXPENDITURES FOR SPECIALTY GROUP SPEAKERS

Georgia Radiological Society, 1 speaker	$ 418.20
Georgia Gastroenterologic Society, 1 speaker	500.00
Georgia Association of Pathologists, 2 speakers	500.00
Georgia Society of Plastic Surgeons, 1 speaker	500.00
Georgia Thoracic Society, 3 speakers	1,000.00
American College of Physicians—Georgia 3 speakers	510.74
Coffee breaks, administration, mailing	303.38
Georgia College of Surgeons, Georgia Chapter, 4 speakers	400.00
Georgia Neurological Association, 1 speaker	500.00
Georgia Society of Ophthalmology	0
Georgia Neurosurgical Society	0
Georgia Society of Internal Medicine	0
TOTAL	$4,632.32

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REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered the excellent report of the Chairman of the Committee on Annual Scientific Assembly and commends the committee for the fine work it did in planning a successful 1975 Scientific Assembly. The report contains a number of recommendations, calling for the MAG to continue its sponsorship of the Annual Scientific Assembly by furnishing the necessary financial support, to continue to reimburse specialty societies for their part in the program, to set aside a portion of the MAG dues to cover the cost of the Assembly, to permit the MAG's Direc-



Delegate Ted Cash of Lafayette picks up reference committee reports early Sunday morning for review before the House of Delegates meets. Charles Rey (R) of Austell,



a member of the Tellers Committee, slips his vote for Association officers in the ballot box next to R. J. Moye of Swainsboro.

tor of Education to hire a part-time administrative assistant to help in the coordination of the Assembly, to appoint a new physician member to serve on the planning committee each year, to expand the Assembly to two full days in 1976, and to apply to the AMA and the American Academy of Family Physicians for accreditation of the Assembly. Your Reference Committee heard favorable testimony on the Scientific Assembly and its importance both to the MAG and to the specially societies taking part. Your committee recommends that all of the recommendations be approved, with the exception of Recommendation 3, which should be referred to the Finance Committee, and Recommendation 4, which should be deleted. Your Reference Committee feels that it is not within its authority to determine to what extent the Scientific Assembly should be supported financially by the MAG. This decision must be made by the Finance Committee. Since MAG has recently hired a new assistant who will help in the coordination of the Scientific Assembly, there is no longer a need for the recommendation that an administrative assistant be hired to help MAG's Director of Education coordinate the Assembly.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Annual Scientific Assembly with the exception of Recommendation 3 calling for a portion of MAG dues to be set aside for the Assembly observing that in lieu of adoption this matter should be referred to the Finance Committee; and by deletion of Recommendation 4.

COMMITTEE ON EDUCATION
EDUCATION COORDINATOR

Nicholas E. Davies, M.D.

BACKGROUND

In my report to the 1974 House of Delegates as Chairman of MAG's Education Committee, I called upon the MAG to accept "the primary responsibility for the continuing education of the physicians within the state and for providing continuing input into all aspects of the general health education of the people of Georgia." To accomplish these ends I made the following recommendation:

> That the Medical Association of Georgia endorse the concept of a full-time educational coordinator on the staff whose job it would be to coordinate all educational activities and scientific sessions within the organization.

Reference Committee C concurred with this recommendation and recommended further that the new staff activity be pursued on a two-year basis, with a report to be presented to the 1976 annual meeting of the House of Delegates containing a full statement on the activities that have been accomplished.

The House of Delegates adopted these recommendations, and on October 1, 1974, Stephen L. Daniel was hired to be MAG's Assistant Executive Director for Education. Dr. Daniel has a background in education, holding a doctorate in humanities from Emory University and having taught at the secondary and college levels. Half of Dr. Daniel's salary during the 1974-75 fiscal year was funded by the Georgia Regional Medical Program. His entire salary for the 1975-76 fiscal year is being funded by GRMP, with the understanding that the MAG, with the approval of its House of Delegates, will assume responsibility for full funding of the salary from such time as GRMP funding is discontinued.

CONTINUING MEDICAL EDUCATION

The primary responsibility of MAG's Assistant Executive Director for Education is to be the lay leader for the continuing medical education (CME) of physicians in Georgia. This role has entailed extensive liaison with CME leaders in various settings: community hospitals, the medical schools, county medical societies, medical specialty societies, voluntary health organizations, the producers of educational materials, and public agencies.

Recognizing the danger of fragmentation in such a rapidly expanding field as CME, Dr. Daniel has been

intent upon stressing coordination and evaluation of the quality of existing CME programs in the state. It is in fact the position of the Education Committee, working closely with Dr. Daniel, that the MAG should not necessarily provide extensive CME but rather serve as a shepherd of all available CME resources so that every physician in the state may have ready access to continuing education of genuine quality.

ACCREDITATION PROGRAM

MAG's principal means of overseeing the coordination and quality of existing CME resources is its program of accreditation. The AMA has delegated the MAG as its accrediting agency for those medical institutions and organizations in Georgia whose CME programs meet established criteria. In the accreditation procedure the MAG's Subcommittee on Accreditation reviews the application of the institution seeking accreditation, and if all is in order, a team of volunteer physicians and MAG staff is sent to the institution to observe an actual CME activity in progress and to interview the institution's CME leaders. A full report is then presented to the Education Committee for final approval. Dr. Daniel has been director of this program which, as of March 15, 1976, has been responsible for accrediting eight hospitals, four medical specialty societies, a voluntary health organization, and a county medical society. At least 30 other institutions are actively working toward accreditation, thus keeping Dr. Daniel busy in a consultative role as he visits hospitals and medical societies throughout the state. To give an idea of how the MAG has distinguished itself in the field of accreditation, only six state medical associations have accredited more institutions than the MAG has.

ANNUAL SCIENTIFIC ASSEMBLY

The MAG is not without its own educational programs for physicians, and one of the Education Director's largest responsibilities is to coordinate MAG's annual Scientific Assembly. The 1975 Assembly—the first to be held independently of the annual business meeting—attracted some 450 physicians from inside and outside the state and provided a forum and speakers' funds for scientific programs sponsored by 12 specialty societies. A detailed evaluation of the meeting is available in a separate report.

BIENNIAL EDUCATION CONFERENCE

Coordination of the Biennial Education Conference, co-sponsored by the MAG and the medical schools, is another of the Education Director's responsibilities. These conferences are designed to prevent a town-gown split in the medical community, with private practitioners and their academic counterparts getting a chance to share their individual concerns about medical education and its relation to practice. The 7th Biennial Education Conference was held on March 5-7, 1976, in Macon, with some 70 physicians in attendance. An important part of the Education Director's work has been his liaison with the medical schools. The reason for this is that the MAG is not competing with the medical schools in the provision of CME but rather serving as a catalyst to encourage physicians to take advantage of the educational opportunities available to them through the schools.

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ASSISTANCE TO HOSPITAL EDUCATORS

Since education is most beneficial when it is experience-centered, the local community hospital has become an ideal environment for CME. The MAG is desirous of fostering CME programs in hospitals throughout Georgia so that no physician will be without a convenient opportunity for ongoing continuing education. Dr. Daniel has consequently organized an itinerary which takes him around the state to speak to and consult with educational leaders in the hospitals. Subjects discussed are educational objectives, curriculum planning, educational needs assessment (through such means as patient care evaluation), and the identification of appropriate educational resources and methods. In April, 1975, MAG sponsored a one-day workshop for hospital-based medical educators which was well attended. A follow-up workshop on methodology in CME is contemplated. An Educational Resource Bank —a kind of speakers bureau—has also been established within MAG's Division of Education as an educational service to hospitals. Hospital physician groups seeking continuing education in particular medical fields may request of MAG the names of those educators who are willing to travel to the hospital to provide the education. The names are supplied by the medical schools, specialty societies, and voluntary health organizations.

SERVICE TO INDIVIDUAL PHYSICIANS

MAG's Education Director has taken care not to neglect the educational needs of the individual physician. Dr. Daniel's office has thus become a clearinghouse of information on individualized educational materials such as audiovisual programs, medical information service, and self-assessment examinations. In addition, a detailed medical meeting calendar has been set up in Dr. Daniel's office to help doctors plan their education by keeping track of the numerous meetings in and around the state. This calendar is published regularly in the *Journal MAG*. One issue of the *Journal* has been devoted entirely to medical education, while another issue provided a form designed by Dr. Daniel to help the physician keep an ongoing record of his or her CME activities. The form may be used as the physician's application for the AMA's Physician's Recognition Award, a program which Dr. Daniel and members of the Education Committee have been active in promoting.

As indicated in my report to the 1974 House of Delegates, MAG's Director of Education should play a role in "the general health education of the people of Georgia." It is hard to know where to begin in a field so vast, but Dr. Daniel has been assisted by members of the new Subcommittee on Public Education in determining priorities for the MAG's efforts in this area. These priorities are 1) the promotion of preventive medicine through improved health education curricula in the schools, 2) patient education, and 3) consumer health education through the public media.

After consulting with the Assistant Director of AMA's Department of Health Education, Dr. Daniel proceeded to establish liaison with the Georgia Department of Education, the Public Health Division of the Department of Human Resources, the Bureau of Health Education (at CDC), the State PTA, and the

voluntary health organizations in order to promote improved health curricula in the schools. The MAG continues to work on this project in coalition with other interested groups, since it is felt that a united front in the health education field is required to alert the public to the problems and to approach the legislature with realistic proposals for improvement.

In the area of patient education, Dr. Daniel has been conducting an ongoing inventory of the resources and programs throughout the state, and it is hoped that the MAG will assume a role of leadership in coordinating, developing, and publicizing such activities.

MAG's Subcommittee on Public Education recognizes the use of the public media as a potentially invaluable method of teaching people how to live healthy lives. Dr. Daniel therefore visited the Georgia Center for Continuing Education in Athens to learn about the kinds of media which are suitable to and available for consumer health education. In addition, contacts are being made with both educators and representatives of the media in order to initiate activities which will involve the MAG in this form of preventive medicine.

NON-PHYSICIAN HEALTH PROFESSIONALS

The education of non-physician health professionals, since it is vital to the health care system in Georgia, is of natural concern to the MAG and its Education Director. Dr. Daniel therefore staffs MAG committees on nursing, allied health, and physician assistants which look into the training, utilization, and continuing education of these professionals.

CONCLUSION

To conclude this report, MAG's Assistant Executive Director for Education has become a valuable asset in the MAG's efforts to serve both its own members and the citizens of the state. He is MAG's educational expert who devotes his talents to promoting and coordinating all educational programs of benefit to the practice of physicians and other health professionals, and to the health of the general public.

RECOMMENDATION

In view of the Education Director's important accomplishments and ongoing work for the association, the MAG should assume full responsibility for the continued funding of this staff position.

REFERENCE COMMITTEE RECOMMENDATION —This report described the work of MAG's Director of Education, Dr. Stephen Daniel, over the last two years and recommends that the MAG assume full responsibility for the continued funding of this staff position in view of the importance of this on-going work. All testimony heard on this report was favorable, and your Reference Committee recommends full approval of this report and its recommendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Education regarding the Education Coordinator.

SECRETARY CONTINUING MEDICAL EDUCATION

Earnest C. Atkins, M.D.

RECOMMENDATION

Encourage the Education Committee to study and make recommendations for each MAG member to continue his medical education so that he may qualify for the AMA Physician's Recognition Award.

REFERENCE COMMITTEE RECOMMENDATION —This recommendation encourages the Education Committee to study and make recommendations for each MAG member to continue his medical education so that he may qualify for the AMA's Physician's Recognition Award. The Reference Committee heard testimony to the effect that the Education Committee already has promoted the Physician's Recognition Award through its Subcommittee on Physician's Recognition Award and through publicity in the Journal MAG. **The Reference Committee recommends that the recommendation be approved with the following changes: "Encourage the Committee on Education to continue to study and make recommendations to each MAG member to continue his medical education so that he may qualify for the AMA's Physician's Recognition Award."**

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary as amended by the Reference Committee.

COMMITTEE ON EDUCATION CONTINUING MEDICAL EDUCATION AS A REQUIREMENT FOR MAG MEMBERSHIP

Nicholas E. Davies, M.D.

All professions must accept in theory that continuing education is basic to their intellectual and professional survival. The heroic age of medicine in America (Osler, Welch, Halstead) established two basic principles for achieving the goals of medical excellence: 1) physical, biological, social, and behavioral sciences must provide the underpinning of medical education: 2) the physician must remain a "lifelong student." However, acceptance of principles is one thing, and putting them into practice is another.

Over the last four years the Education Committee has devoted considerable energy and time to ways of putting the principles of continuing medical education (CME) into practice. The committee now recommends that the Medical Association of Georgia make CME a requirement for membership. This recommendation may not be a popular one initially with a number of MAG members, but it represents the natural progression of the committee's studies and discussion.

Social forces, such as the growth of the concepts of public accountability and the public's right to health care, are exerting pressures on organized medicine to which we must respond. Public expectation will be heightened even further as our national legislative processes seem bound headlong toward a national health insurance program. Despite our many misgivings and admonitions, the failure to enact national health insurance legislation now seems simply a postponement owing to economic concerns rather than a policy decision negating the concept. Cost containment will continue in a more aggressive way, and performance of professionals in health institutions will become more a part of the public record. The media will play a larger role in the assessment of the quality of care. A physician's knowledge base suitable for the practice of medicine will have to be continually updated and enlarged,

and re-certification for medical licensure may be generally applied. With rising expectations, and with greater visibility of medical performance, a tight system of public accountability will become a dominant characteristic of all aspects of health care, including health education.

The following trends would seem to make the requirement for CME by medical societies a professional responsibility:

1. The interest of state legislatures in the quality of medical care as a popular political issue.
2. The attractiveness of CME to state boards of medical examiners as a means of meeting their responsibilities for the quality of physician services within the state.
3. The informally expressed interest of the insurance industry concerned with practice liability in having the potential of CME programs put to use for reducing malpractice claims and suits.

The present-day national statistics in regard to requirements for CME are these:

1. Fourteen state medical associations now have requirements for CME as a requisite for membership.
2. Six medical specialty societies have made the policy decision to require certain levels of documented CME.
3. All 22 medical specialty boards have established the policy to require re-certification with its assumed requirement for CME. Three (family practice, surgery, and thoracic surgery) have made the requirement mandatory.
4. Eight states have the authority to require evidence of CME as a requisite for re-licensure.
5. Nineteen state osteopathic associations have requirements for CME for membership.
6. Many state legislatures are incorporating requirements for evidence of CME into their malpractice legislation.

The Oregon Medical Association was the first state medical society to establish a CME requirement for membership. This occurred in 1970. During the first year of the requirement it lost less than one percent of its 2,500 members. At the end of three years' experience it had lost six physicians due to suspension for non-fulfilment of the requirement. The cost of the program was $3.63 per member for the first year and subsequently $7.00 per member for the subsequent three-year period of operation. Benefits of the requirement are as follows:

1. Increased attention of physicians to the relevance and quality of CME programs.
2. Local concern regarding programs and attendance at these programs.
3. The Scientific Sessions of the Oregon Medical Association have increased in significance.
4. There has been increased attendance at all educational meetings within the state.

(See Augustus M. Tanaka, M.D., *Federation Bulletin,* September, 1975, pp. 265-74.)

New Mexico was the first state to implement a requirement for documented CME for re-licensure. New Mexico has approximately 1,767 physicians, and this requirement was instituted in 1972. The requirement includes 120 hours of documented CME over a three-year period. It came about as a recommendation to the House of Delegates of the New Mexico Medical Society from the Committee on Continuing Education,

REFERENCE COMMITTEE D

and in turn the Association sponsored a bill in the Legislature. The New Mexico Medical Society rejected the requirement of CME for membership in the state society because it recognized that only 80 percent of the physicians in the state were members of the Medical Association, and it felt that the requirement was of such importance that all physicians should be affected.

The American Academy of Family Physicians was the first specialty society to institute a requirement of CME for membership, and the American Board of Internal Medicine was the first specialty board to have a voluntary re-certification examination, with 3,000 physicians participating in the first exam.

The following choices would seem to be open to The Medical Association of Georgia:

1. Do nothing.
2. Continue to promote the development of CME programs in community hospitals within the state.
3. Continue to encourage voluntary fulfilment of the CME requirements for the AMA's Physician's Recognition Award.
4. Make fulfilment of the CME requirements for the Physician's Recognition Award a requirement for membership in the state medical society.

Eventualities over which we might have no control include the following:

1. The state legislature might require fulfilment of certain continuing education requirements for re-licensure.
2. The insurance industry may institute requirements for continuing education before malpractice insurance is issued.
3. Specialty societies may require evidence of CME.
4. Re-certification by our various specialty boards may become necessary either on a voluntary or involuntary basis. The basis for this re-certification may include formal testing or evidence of CME or both.
5. The federal government through national health legislation may impose requirements of its own.

Weighing the options against the above factors, the committee makes the following recommendation to the House of Delegates:

RECOMMENDATION

That membership in the state medical association include the requirement of satisfying the continuing education criteria for the Physician's Recognition Award of the AMA or for membership in the American Academy of Family Physicians. Allowances for health, financial difficulty, etc., would be made, and an appeal mechanism would be built in. There would be an open-ended period for implementation.

Certainly the CME requirement will never be successful unless it is supported by the physicians in the state. We offer this recommendation not as a punitive measure but as evidence of organized medicine accepting its responsibility. The scope of the Physician's Recognition Award is broad-ranged and offers almost unlimited opportunity for physicians to achieve their educational needs in any manner. The requirement would make physicians more aware of their individual educational needs. They would then insist on having quality education available throughout the state. Certainly there are enough programs available now on a national,

regional, state, and local basis so that physicians would have no difficulty in fulfilling the requirements. We would continue our efforts with local hospitals to establish excellent programs of continuing education. Our acceptance of this responsibility would be further public evidence that we are willing to meet our responsibilities in the face of public scrutiny.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee gave careful consideration to a special report of the Committee on Education which contained the recommendation that membership in the MAG include the requirement for satisfying the continuing medical education criteria for the Physician's Recognition Award or the CME requirement for membership in the American Academy of Family Physicians. Reference Committee D heard excellent testimony both in support of the recommendation and in opposition to it. However, the committee observed that most of those offering testimony were opposed to making continuing medical education a requirement for membership in the MAG. The most compelling reason for this opposition was that criteria have not been established for properly evaluating either the quality of existing CME programs or the relevance of CME to the improvement of patient care. Your Reference Committee recommends that the recommendation of the Committee on Education be disapproved, since the committee received no convincing data to prove that required CME would result in improved medical care.

HOUSE OF DELEGATES ACTION—Voted to not approve the recommendation of the Committee on Education regarding continuing medical education as a requirement for MAG membership.

Chairman Menendez expressed his appreciation to the members of the Reference Committee and to the MAG staff for their time and effort in the preparation of this report.

REPORT OF REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

ROBERT W. OLIVER, M.D., *Chairman*

Chairman Oliver reported to the House of Delegates that the reports and resolutions referred to the Reference Committee on Constitution and Bylaws had been considered by the Committee which met at 2 p.m. in Colony Hall of the Holiday Inn, Jekyll Island, on April 9, 1976. Members of the Reference Committee present included Robert W. Oliver, M.D., Dublin, Chairman; Michel A. Glucksman, M.D., Brunswick, Vice Chairman; Frank Johnston, M.D., Savannah; Joe S. Wilson, M.D., Atlanta; John P. Heard, M.D., Decatur; E. Van Herrin, M.D., Athens.

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D.

Item 1: Election of Speaker and Vice Speaker (Item 8, C & B Report, 1975)

The 1975 House of Delegates was presented with proposed amendments that would require that the Speaker and Vice Speaker be elected *from among* the members of the House and change their terms of office from three years to one year. The House referred the proposition back to the C & B Committee to rewrite the amendment to provide for the election of the Speaker and Vice Speaker for a three year term. Since the present C & B already stipulates a three year term for the Speaker and Vice Speaker, the amendment below deals only with how and by whom those officers are elected. Those proposed amendments also remove from *Chapter IV, House of Delegates and Chapter VII, Rights and Duties of Officers* all references to the election and terms of the officers and leaves this reference in *Chapter VI, Officers of the Association and Their Election* with the remainder of the officers, redundancy being the reason for this deletion.

These need not be a Constitutional Amendment since *Article IX, Officers,* does not specify how all other officers are elected or who elects them.

Note: Existing wording appears here as is. Suggested amendments by **addition** are indicated by **boldface type.** Amendments by *deletion* are indicated by *italicized type.* It is possible to read the wording as it is suggested. Only those sentences preceding and succeeding a suggested change that help to identify the suggested amendment are shown here.

CHAPTER VI

OFFICERS OF THE ASSOCIATION AND THEIR ELECTION

"Section 1. Officers and Terms of Office. The officers of the Association are the President, President-Elect, two Vice Presidents, the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the Vice Speaker of the House of Delegates, and the Councilors and Vice Councilors. The President-Elect shall be elected annually and shall become President at the time of next Annual Session. The Speaker of the House of Delegates **and** the Vice Speaker of the House of Delegates **shall be elected from among the members of the House of Delegates and** shall serve for terms of three years **provided each shall remain a duly elected delegate.**, *the* **The** Secretary, the Treasurer, and the Councilors and Vice Councilors shall serve for terms of three years. . . ."

CHAPTER IV

HOUSE OF DELEGATES

"Section 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice Speaker. In the absence of both, a delegate agreeable to it may preside. *The Speaker and Vice Speaker shall be elected by the members of the House of Delegates and shall serve for a term of three years."*

CHAPTER VII

RIGHTS AND DUTIES OF OFFICERS

"Section 6. Speaker. The Speaker of the House of *Delegates shall serve for three years after being duly elected by the members of the House of Delegates and he* shall preside over all meetings of the House of Delegates. . . .

Section 7. Vice Speaker. The Vice Speaker of the House of Delegates *shall serve for three years after being duly elected by the members of the House of Delegates and he* shall preside over the House of Delegates in the absence of the Speaker. . . ."

Item 2: Unified Membership (Item 4, C & B Report, 1975) tabled by House of Delegates.

This amendment would require membership to be maintained in the component society and MAG. As presented to the House of Delegates in 1975, there was concern over the mechanism for implementing this requirement.

It was also noted that a special situation exists in extreme northern Georgia where physicians from a neighboring state wish to be members of the Walker-Catoosa-Dade Medical Society. The Reference Committee recommended that this be recognized in any amendment requiring unified membership.

The following amendment is proposed to answer the above concerns.

CHAPTER VIII

COMPONENT COUNTY SOCIETIES

"Section 1. County Societies. . . . A component society shall consist of five or more active members."

"Section 2. Unified Membership. Applications for membership in a component society must be accompanied by application for membership in the Medical Association of Georgia. The application for membership in the Association will be approved upon the certification by the secretary of the component society that the application to the component society has been approved and the new member is in good standing. Membership must be maintained in the Association and in the component society. This provision shall not apply to those physicians who practice and reside in an adjacent state and who are members in good standing of the state medical association in the state of their residence and practice."

There is some feeling that an active member of another state medical association should not be permitted to be an active member of a Georgia component medical society unless he has the same responsibilities of membership as any other active member. At the same time these out-of-town physicians should be recognized with a special category of membership for their contribution to the activities of the component society. It is suggested that as an alternate method of accomplishing unified membership the present classification of "Affiliate Member" be amended to include these physicians from neighboring states. Amendments to accomplish this are as follows:

CHAPTER VIII

COMPONENT COUNTY SOCIETIES

"Section 2. Unified Membership. Application for membership in a component society must be accompanied by application for membership in the Medical Association of Georgia. The application for membership in the Association will be approved upon the certification by the secretary of the component society that the application to the component society has been approved and the new member is in good standing. Membership must be maintained in the Association and in the component society."

REFERENCE COMMITTEE ON C & B

CHAPTER II

MEMBERSHIP

"Section 5. Affiliate Member. G. Physicians, who live in adjoining states and whose predominate practice is in the state of their residencies and who are members in good standing of the county and state medical associations in their state of residence."

Item 3: Life Membership (referred by Council).

The present bylaws authorize Council to approve life Membership status for a physician who has been an active dues paying member of MAG for "less than 10 years." This could be 10 years or 0 years. Council instructed the Committee to prepare language that would provide for a minimum number of years of required active status before Life status is granted. The Committee feels that a minimum of one year is reasonable.

CHAPTER II

MEMBERSHIP

"Section 7. Life Members. . . . his application may be granted upon action of Council if he has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years provided he has been an active dues-paying member of this Association *for less than 10 years* **for at least one year.**

Item 4: Committee Maximum Size. The Executive Committee of Council requested the C & B Committee draft language that would delete the requirement to specify the number of members which serve on special committees.

CHAPTER XI

SPECIAL COMMITTEES

"Section 1. Special committees as required for the conduct of the business of the Association shall be instituted, and members thereof appointed, by Council of the Association with or without the recommendation of the Executive Committee of Council, by the Executive Committee of Council, or by the House of Delegates of the Association. The House of Delegates may instruct Council to institute and appoint members to particular special committees. *The number of members of each special committee and the method of their appointment* **The method of the appointment of special committees** shall be specified in the resolution instituting the particular special committee. . . ."

Item 5: Finance Committee (Item 7, C & B Report, 1975). Referred by House of Delegates to Executive Committee (November 1975) and back to the C & B Committee.

The Executive Committee agreed that the sense of the House of Delegates was to accept the amendments that would make the Treasurer the Chairman of the Finance Committee and instructed the C & B Committee to prepare the appropriate language to make this change.

CHAPTER VII

RIGHTS AND DUTIES OF OFFICERS

"Section 4 (B) Treasurer. . . . He shall be an officer of the Association and a voting member of Council and of the Executive Committee of Council. **He shall serve as the Chairman of the Finance Committee.** He shall be an ex-officio member without the right to vote of the House of Delegates. . . ."

CHAPTER IX

FUNDS AND EXPENDITURES

"Section 1. Treasurers Duties. The Treasurer shall receive all funds of the Association with bequests and donations. . . . All checks for Association expenditures shall be signed by both the Treasurer and the Secretary, or by any two officers of the Association designated by Council. **The Treasurer shall serve as the Chairman of the Finance Committee.**

CHAPTER V

COUNCIL

"Section 9 **(a)** Committee on Finance. **The Treasurer shall serve as the Chairman of the Committee on Finance.** The Chairman of Council shall appoint from among its members three members to be known as the Committee on Finance, . . ."

The Executive Committee directed the C & B Committee to prepare language that would impose a limit on the amount of unbudgeted funds that Council could spend.

"Section 9 (b) Unbudgeted Funds. Council shall submit any proposal for the expenditure of unbudgeted funds in an amount in excess of four percent (4%) of the total annual budget to the Finance Committee for review and recommendation to Council at the next meeting of Council."

Item 6: The following Constitutional Amendment was approved by the 1975 House of Delegates and relates to the expansion of statement of purposes of the Association. This amendment has been laying on the table for its required year and now requires the final vote of the House.

"The purposes of the Association are to promote the science and art of medicine and the betterment of public health **as provided for in the Bylaws."**

IMMEDIATE PAST PRESIDENT

John Rhodes Haverty, M.D.

I will have finished my last of 10 years on the MAG Executive Committee by the time this report is given to the House. This past decade has been exciting and productive for me, and full of change for the Association. I hope my service to organized medicine in Georgia has been effective and useful, and I pledge my continued interest and support for the future in its behalf.

Problems, even "crises," will persist, and will plague our organization for the forseeable future. I believe sincerely we will cope with them, and will maintain the pursuit of our primary goal in life as physicians: that of serving our fellow man with dignity and humility by utilizing those talents and skills which we possess.

The ever-increasing involvement by other than physicians in the delivery of health care will grow. We must be vigilant in safeguarding not our own selfish interests, but those of our patients, and by doing so will retain the respect and love we have earned throughout the past.

There are many specific issues I feel warrant our particular concern, some of which I have brought before this House over the past several years, and some of which will be addressed in other reports to you this year. I will not reiterate them here.

I will speak to one recommendation, however. To accomplish our mission, to be an effective agent for good health for our society, we must be united. Like the old Roman fascis that could not be broken when melded together, we must gather ourselves as a single and cohesive unit.

RECOMMENDATION

I recommend that we require membership in the Medical Association of Georgia for all physicians in all county societies within Georgia. This will strengthen our Association financially, politically, scientifically, and socially. It is time now, in 1976, to say to all, "We are one unified group of physicians in Georgia."

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered each item of this report separately.

Item 1. Election of the Speaker and Vice Speaker. The 1975 House of Delegates requested that the Committee on Constitution and Bylaws draft language to provide for the election of the Speaker and Vice Speaker from among its members and to provide for three year terms. Since the Bylaws already provide for three year terms for both offices no new amendments are required. In addition to providing this language, the Committee on Constitution and Bylaws recommends certain changes in the Bylaws that would remove all redundant reference to the procedures for electing the Speaker and Vice Speaker.

Mr. Speaker, your Reference Committee heard testimony from interested members with few comments in opposition to this principal. Your Reference Committee feels it entirely appropriate that the Speaker and Vice Speaker be elected from among the members of the House of Delegates.

Mr. Speaker, your Reference Committee identified the following typographical errors in the amendments provided by the Committee on Constitution and Bylaws:

1. Item 1, Chapter VI, Section 1 repeats the phrase "Vice Speaker" which is redundant.

2. Item 1, Chapter VII, Section 6 has Delegates in "House of Delegates" struck through.

Mr. Speaker, your Reference Committee recommends that these clerical errors be corrected.

Mr. Speaker, your Reference Committee recommends that the Bylaw amendments as set forth in Item 1 of the Report of the Committee on Constitution and Bylaws be adopted with the above listed corrections.

Item 2. Unified Membership.

Mr. Speaker, the report of the Immediate Past President concerning unified membership was considered along with Item 2 of the report of the Committee on Constitution and Bylaws.

Item 2 provides language to amend the Bylaws to require that membership be maintained in the county

medical societies and MAG.

Your Reference Committee heard lengthy testimony regarding this matter. Our conclusions are based on the following:

1. The present Constitution and Bylaws seem to imply that it was never intended that a component society, chartered by MAG, should have members that are not members of the parent organization (Reference: Constitution, Article IV, Section 1, Article III, Article X; Bylaws Chapter II, Section 1 (D), Chapter IX, Section 2).

2. The main objection to unified membership expressed by the 1975 House of Delegates was the lack of provisions for out of state physicians practicing in Georgia.

3. The values of some form of unified membership manifest themselves in many positive ways. The fact is that every Georgia physician, regardless of membership status, benefits from the many programs of the Association, lower professional liability insurance rates negotiated by the Association being one of them. One cannot reasonably assign a dollar value to the public relations, legislative effectiveness, that unified membership could bring our Association. Hopefully, unified membership would lead to increased income and an overall strengthening of our Association.

4. It is recognized that an increase in dues may be forthcoming at this Annual Session and because of this, the implementation of unified membership may appear to be ill-timed at present. However, your Reference Committee felt that the obvious and implied benefits of unified membership are needed to strengthen the Association now.

Mr. Speaker, your reference committee recommends the adoption of the recommendation for unified membership contained in the Report of the Immediate Past President.

Mr. Speaker, your reference committee recommends that Chapter VIII of the Bylaws be amended by the addition of the first alternative, New Section 2, offered by the Committee on C & B.

Item 3. Life Membership.

This proposed amendment would change the Bylaws to provide for a specific time requirement for active membership in MAG before the granting of Life Membership by Council.

Mr. Speaker, your Reference Committee recommends that Chapter II, Section 7, of the Bylaws be amended as stated in Item 3 of the Report of the Committee on C & B.

Item 4. Committee Size.

This proposed amendment removes the requirement that a maximum size for committees be set at the time of the creation of the committee.

Mr. Speaker, your Reference Committee recommends that Chapter XI, Section 1 of the Bylaws be amended as indicated by the language in Item 4 of the report of the Committee on C & B.

Item 5. Finance Committee.

This series of amendments would name the Treasurer as the Chairman of the Finance Committee.

Your Reference Committee heard testimony favoring this change and agrees that the change would make the office of treasurer a more meaningful office and remove what could now be considered a duplication of responsibility.

Mr. Speaker, your Reference Committee recommends that Chapter VII, Section 4 (B) and Chapter IX, Section 1, and Chapter V, Section 9 (a) be amended as stated in Item 5 of Report of the Committee on Constitution & Bylaws.

A second part of Item 5 or the report addressing Bylaws, Chapter V, New Section 9 (B) requires Council to submit a proposal for the expenditure of unbudgeted funds in amount exceeding four percent of the Annual Budget to the Finance Committee for review and recommendation.

Your Reference Committee heard testimony that this proposal was to give Council time to consider more thoroughly the expenditure of large sums of money. It was pointed out that all the members of the Finance Committee are usually members of Council.

Philosophically, your Reference Committee feels that since the members of Council are your duly elected representatives who have been given the constitutional authority to manage the affairs of the Association when the House of Delegates is not in session, they then should enjoy the confidence of the House of Delegates to do as they are charged.

Mr. Speaker, your Reference Committee recommends that Chapter V, Section 9 (B) new proposed bylaw amendment as stated in Item 5 of the Report of the Committee on C & B be not adopted.

Item 6. Constitutional Amendment—Expansion of MAG Purposes.

This amendment was introduced in the 1975 House of Delegates in conjunction with a Bylaws amendment. The Bylaws amendment was adopted by the 1975 House and this constitutional amendment has "lain on the table" for the required one year.

Mr. Speaker, your Reference Committee recommends that Article II, of the Constitution be amended as stated in Item 6 of the Report of the Committee on Constitution & Bylaws.

HOUSE OF DELEGATES ACTION—Adopted Item 1 of the Report of the Committee on Constitution and Bylaws with the editorial corrections noted by the Reference Committee. Item 2 of the Report was adopted. In adopting Item 2, the House accepted the recommendation of the Reference Committee that the new Section 2, "first alternative" offered by the Committee on Constitution and Bylaws also be adopted. Item 3 of the Report was adopted. Item 4 of the Report was adopted. Item 5 of the Report was not adopted. Item 6 of the Report was adopted.

REFERENCE COMMITTEE ON C & B

AD HOC COMMITTEE ON ORGANIZATION AND FUNCTIONS

J. Rhodes Haverty, M.D.

At the beginning of this report, it would be well that the House of Delegates be reminded that the Organization and Functions Committee was created pursuant to a resolution of the House that saw a need for a comprehensive study of all significant aspects of MAG from organization to activities. In its wisdom the House provided that the study should be conducted by a seven man committee and that a majority thereof be MAG members not associated with the "medical establishment." The House obviously wanted grassroots input.

That was in 1973.

Since that time, this committee has met on a regular basis and, although the membership of the committee has been subject to almost a complete turnover (only one original member still serves), one view has been consistently held by the committee, i.e., substantial reorganization of our governing structure was needed. It is interesting and significant to note that the minutes of the first meeting of this committee on October 28, 1973, state:

> "General discussion of the organization of Executive Committee and Council was held. Several viewpoints were expressed, including an observation that Council had grown so large and was directing its attention to so many subject areas as to make scholarly, deliberative consideration of the truly important items virtually impossible."

The report of the committee to the 1975 House of Delegates primarily addressed itself to a massive reorganization of the Council and included all of the constitutional amendments necessary to accomplish the reorganization effort.

Although Reference Committee D recommended adoption of the Organization and Functions Committee report, the House felt the matter should be returned to the Organization and Functions Committee for a year's additional study and deliberation.

Thus the Organization and Functions Committee met twice during this past year to consider the action taken by the House and to continue study of the organizational structure of the Association. The results of this study follow. The committee feels three fundamental changes should be adopted by the House of Delegates. To accomplish these changes will require numerous amendments to the Constitution and Bylaws. It should be noted, however, that the large number of amendments are merely repetitions of three basic concepts. These concepts are:

CONCEPT I

The committee feels a name change from Council to Board of Directors is advisable as the term Council invariably requires clarification when used in a public utterance and, in fact, is not fully understood even by the MAG membership. Seven of the 13 Articles of the Constitution and virtually every Chapter of the Bylaws would have to be amended to effect this proposed change in name. *The committee will present later in this report the necessary constitutional changes so they may begin to lay on the table to be voted on at the 1977 session. Corresponding Bylaws amendments will not be presented until 1977.*

CONCEPT II

Change the officers. The committee feels the need to streamline the officer structure by eliminating certain positions and redefining the duties and status of others. Specifically it will be recommended that the officers of the Association be comprised as follows: President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker of House of Delegates, Chairman of AMA Delegation.

Under this plan, the President would serve as the Chairman of the Board and would preside at meetings of the Board. The President-Elect would be the Vice Chairman.

The President-Elect would fill the purpose of the Vice President; namely, he would ascend to the presidency in the event the President is unable to serve. He would fill the unexpired term of the President and then be permitted to fill the office to which he was elected in his own right.

The Immediate Past President would serve on the Board of Directors for one year.

The Secretary, Treasurer and Speaker would continue to be elected for three year terms of office and eligible to succeed themselves for one additional term.

It is anticipated that the Treasurer will function as Chairman of the Finance Committee.

The Chairman of the AMA Delegation would be elected by Executive Committee for a two year term (to match his term as an elected delegate).

These seven would be members of the Board of Directors and would constitute the Executive Committee of the Board. They would meet only on special call as the plan contemplates that the Board would meet monthly thus making regular meetings of the Executive Committee unnecessary.

CONCEPT III

Election by mail ballot. The committee feels that the number of members who participate in the election of Directors and Alternates should be significantly increased.

Most district medical society meetings are poorly attended and consequently very vew members participate in the election of district representatives. The committee feels the use of a mail ballot will improve this situation considerably and, accordingly, proposes the following:

The Presidents of the various county medical societies in each district would constitute a nominating committee for their district and they would certify a slate of nominees for Director and Alternate Director to the Secretary of MAG by January 31 in each appropriate year.

The Secretary would then prepare a ballot for each such district and send it to all active and life members by February 21. The ballots would then be marked and returned to the chairman of a tellers committee appointed by the Board of Directors from among those not contesting in the election.

The committee feels that the Board of Directors should meet monthly as the business of the Association simply cannot be deferred for periods up to three months. The current Bylaws provide that the Board (Council) meet at the close of the Annual Session to organize and then meet a minimum of three times prior to the next Annual Session. While there is a minimum on the times the Board must meet there is no maximum. The committee feels that monthly meetings of the Board could be held pursuant to a resolution by the Board in response to a suggestion by the House. No amendments will be required for this change to take effect.

To accomplish these changes both the Constitution and the Bylaws must be amended. As is required, Constitutional amendments cannot be voted on until they have been received by the House and permitted to "lay on the table" for a year. Thus the amendments to the Constitution later presented in this report cannot be adopted at this meeting, indeed, they cannot even be

voted upon until the Annual Session of 1977. However, unless they are received now and begin to "lay on the table," we will lose an entire year and the earliest the House could then express its views on the important subject of this report would be the Annual Session of 1978. Assuming these Constitutional amendments are received now the Organization and Functions Committee plans to present complementing amendments to the Bylaws at the 1977 Annual Session at which time the House would consider these along with its consideration of the Constitutional amendments.

The following Constitutional amendments are presented (those portions which are proposed deletions are indicated by italicized type, the proposed new language is in boldface):

ARTICLE VI.

COUNCIL **BOARD OF DIRECTORS**

Section 1. Composition. *Council* **The Board of Directors** is composed of the President, the President-Elect, the Immediate Past President, *the two preceding Immediate Past Presidents, two Vice Presidents,* Secretary, Treasurer, Speaker of the House of Delegates, **Chairman of the Delegation to the American Medical Association** and *Councilors* **Directors** as provided for in the Bylaws. *Delegates and Alternate Delegates to the AMA, Editor of the Journal, Past Presidents other than the three immediate Past Presidents and the Executive Director shall be ex-officio members of Council without the right to vote. Vice Councilors* **Alternate Directors** shall be ex-officio members except in the absence of their respective *Councilors* **Directors** as provided for in the Bylaws.

Section 2. Duties. The *Council* **Board of Directors** is *the Board of Trustees and* the Board of Censors of the Association. It carries out the mandates and policies as determined by the House of Delegates. The *Council* **Board of Directors** has full authority and power of the House of Delegates between sessions of that body. The *Council* **Board of Directors** has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws.

ARTICLE VII.

MEETINGS

Section 1. Annual Session. The Association shall hold an Annual Session at a time and place fixed by *Council* **the Board of Directors.**

Section 2. House of Delegates. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by *Council* **the Board of Directors.**

Section 3. Special Meetings. Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of *Council* **the Board of Directors,** or upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

DISTRICT SOCIETIES

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the state into *councilor* districts and for the organization of all component county societies in the districts into *councilor* district medical societies.

REFERENCE COMMITTEE ON C & B

ARTICLE IX.

OFFICERS

Section 1. Designation. The officers of the Association shall be a President, President-Elect, *two Vice Presidents,* the Immediate Past President, the Secretary, the Treasurer, the Speaker of the House of Delegates, the *Vice Speaker of the House of Delegates* **Chairman of the Delegation to the American Medical Association,** the *Councilors* **Directors** and *Vice Councilors* **Alternate Directors** as provided for in the Bylaws.

Section 2. Election and Eligibility. The officers of the Association, with the exception of the *Councilors* **Directors** and *Vice Councilors* **Alternate Directors** shall be elected during the Annual Session as provided for in the Bylaws. *Councilors* **Directors** and *Vice Councilors* **Alternate Directors** shall be elected as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

Section 3. Term of Office for President-Elect. The President-Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-Elect shall be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session.

Section 4. Terms of Other Officers. Other officers shall be elected for terms of one year each except the Secretary, the Treasurer, Speaker of the House of Delegates, *Vice Speaker of the House of Delegates* and the *Councilors* **Directors** and *Vice Councilors* **Alternate Directors** who shall serve for three years. One-third of the *Councilors* **Directors** and *Vice Councilors* **Alternate Directors** shall be elected annually. All officers shall serve until their successors are elected and installed.

Section 5. Successor to the President. If the President dies, resigns, or is removed from office, the *First Vice President* **President-Elect** shall immediately become President and shall serve for the remainder of the unexpired term. If the *First Vice President* **President-Elect** is unable to serve, then the *Second Vice President* **Speaker of the House** shall fill the office.

In event a catastrophic occurrence shall exhaust the aforementioned line of succession to the Presidency, the *Speaker of the House of Delegates or the* Vice Speaker *if the Speaker is unable to act* shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next Annual Session. The Acting President, so named, shall have all the powers and duties of the President during the term for which he is elected to serve. Should *the Speaker and* the Vice Speaker *both* be unable to act, then five *Councilors* **Directors** or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting. Such other acting officers as necessary shall also be named at this time to serve until the next Annual Session.

ARTICLE X.

FUNDS AND EXPENDITURES

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component society. The amount of assessment shall be set by the House of Delegates upon recommendation of *Council* **the Board of Directors.** Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by *Council* **the Board of Directors.** The *Council* **Board of Directors** shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

ARTICLE XI.

OFFICIAL PUBLICATION

The official publication of the Association shall be the Journal of the Medical Association of Georgia in which shall be published all official Association notices, abstracts of transactions of the House of Delegates, and general meetings of the Association, the annual budget, complete financial reports as directed by *Council* **the Board of Directors,** and abstracts of meetings of *Council* **the Board of Directors.**

RECOMMENDATIONS

1. The Ad Hoc Committee on Organization and Functions recommends that the above proposed amendments to the MAG Constitution be received and allowed to "lay on the table" until the 1977 Annual Session at which time it would be called up for a vote of the House to adopt or reject.

2. The Ad Hoc Committee on Organization and Functions recommends that the House of Delegates suggest to the Council that it adopt a resolution calling upon itself to meet on a monthly basis.



Credentials Committee members Frank R. Miller of Sylvania and Julius T. Johnson of Augusta, with staff member Sylvia Barnes, check off the names of Cobb County delegates Evans J. Nichols, Richard Cohen and Donald J. Rooney before the Sunday Session.

REFERENCE COMMITTEE RECOMMENDATION —The report of the Ad Hoc Committee on Organization and Functions was reviewed in great detail. The Chairman of this committee testified at length and comments both pro and con regarding numerous aspects of the committee report were received.

This report made two recommendations that were based on three conceptual narratives which were also phrased as amendments to the MAG Constitution. The three concepts were: (1) change the name of the Council to the Board of Directors; (2) restructure the officer group by designating the President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker of the House and Chairman of the AMA Delegation as officers of the Association, and by re-defining some of their duties; (3) to provide for the election of Directors and Alternate Directors by a mail ballot.

The report makes two recommendations. Specifically, it calls for a series of proposed Constitutional amendments to be received by the House to begin to "lay on the table" to be voted on next year, and, secondly it asks that the House of Delegates suggest to Council that it (Council) meet on a monthly basis.

Your Reference Committee feels that both of the recommendations and the report of this committee should not be approved for the following reasons: Your Reference Committee feels that the Board of Directors should be allowed to elect its own chairman, and thus opposes the recommendation of the Organizations and Functions Committee that the President serve as Chairman of the Board. In addition, your Reference Committee finds no reason that the chairman of the AMA delegation should be designated an officer and a member of the Executive Committee.

Your committee heard criticism of that portion of the report dealing with the "mail ballot." Specifically, the objections centered on the fact that many of the larger metropolitan medical societies felt they should be allowed to elect their Directors and Alternate Directors as they see fit.

Your Reference Committee was advised by legal counsel that Article XIII of the Constitution provides the method by which constitutional amendments may be presented but that this is in apparent conflict with the requirements set forth in Chapter X, Section 6 and Chapter XV of the Bylaws. Your Reference Committee does not question the supremacy of the provision of the Constitution over conflicting views expressed in the Bylaws. While the Reference Committee recognizes that the Organization and Functions Committee acted properly in accord with Article XIII of the Constitution, it nonetheless feels that its (the Reference Committee's) work would have been simplified had the proposed constitutional amendments been referred to the C & B Committee for drafting and general review before the full report was sent to the House of Delegates.

The criticism and objections were interspersed throughout the report, making it difficult for the committee to comment affirmatively on those parts of the report of which it approved and still maintain clarity.

Mr. Speaker, your Reference Committee recommends that the entire report be not approved and that the following be adopted in lieu thereof:

1. Refer the entire matter to Council for subsequent

referral to the Constitution and Bylaws Committee for language drafting to accomplish the following concepts:

a. Change the name from Council to Board of Directors;

b. Designate the officers of the Association to be the President, President-Elect, Immediate Past President, Secretary, Treasurer, Chairman of the Board of Directors, and Speaker of the House of Delegates;

c. Specify that these seven officers shall be members of the Board of Directors;

d. Provide that the President-Elect would serve as the Vice President succeeding to the presidency in the event the President is unable to serve, filling the unexpired term and then serving the full term to which he was elected;

e. Provide for the election of Directors and Alternate Directors by a mail ballot on an optional basis. Your Reference Committee feels that the use of a mail ballot would increase participation in some district societies. However, it noted in Chapter VI, Section 3, of the MAG Bylaws, an apparent prohibition to the use of "mail ballots." Said Section 3 states that Councilors and Vice Councilors shall be elected at the Annual meetings of the district or the component county societies. Your Reference Committee feels, therefore, that the Constitution & Bylaws Committee should also prepare the necessary amendments to remove this prohibition should close examination of the Bylaws reveal that an actual prohibition exists.

Mr. Speaker, your Reference Committee moves the adoption of its Reference Committee's recommendation to disapprove the report of the Ad Hoc Committee on Organization and Functions, and the adoption of recommendation 1 above.

In reviewing the Constitution and Bylaws, your Reference Committee found many conflicts, inconsistencies, and examples of poor draftsmanship. Your committee recommends that the entire document be given an extensive review by legal counsel in an effort to eliminate the above deficiencies, and with a view towards simplifying the Constitution and Bylaws without making changes in substance, and your Reference Committee moves the adoption of this recommendation.

Lastly, Mr. Speaker, your Reference Committee feels that the Ad Hoc Committee on Organization and Functions has dealt superficially with organizational structure and has not attacked the critical problems which confront our Association as they were charged to do by the House of Delegates' adoption of the report of Chairman of Council as amended at the Annual Session in 1973.

A study of the structural and functional problems of Council was begun last year, however, the committee did not address itself in depth to the problem this year. Your Reference Committee believes that this was one of the major charges given this committee originally. (Ref. Proceedings 1973, House of Delegates action, page 203).

Therefore, the Reference Committee recommends that the Ad Hoc Committee on Organizations and Functions be continued as a special committee with good grass roots representation and that it be directed to carry out the original charges given it by the 1973 House of Delegates and the actions taken subsequently on the recommendations of the 1974 and 1975 House of Delegates. (Proceedings, 1973, House of Delegates actions, page 203.) Mr. Speaker, your Reference Committee moves the adoption of this Reference Committee's recommendations.

HOUSE OF DELEGATES ACTION—Voted to not approve the entire report and recommendations of the Committee on Organization and Functions and voted to adopt in lieu thereof, two recommendations made by the Reference Committee shown as Recommendations 1A and E above. Lastly, the House voted to delete from the Reference Committee Report the last three paragraphs of that report and substitute in lieu thereof the following:

"The House dissolves the Ad Hoc Committee on Organization and Functions and commends it for the many hours of devoted labor in behalf of the Association."

REFERENCE COMMITTEE ON C & B

RESOLUTION 14-76
REALIGNMENT OF DISTRICTS

Robert W. Oliver, M.D., and James Kibler, M.D., Laurens County Medical Society

WHEREAS, there is said to be and most probably is a lack of permanence in the Medical Association of Georgia, and

WHEREAS, Council has the responsibility of carrying on MAG business throughout the year, and

WHEREAS, members of Council are elected at the district level, and

WHEREAS, participation by the rank and file of MAG at the district level is not what it should be, now therefore be it

RESOLVED, that an effort be made to improve participation of MAG members at the district level by rearranging the districts to more closely coincide with medical referral areas.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee reviewed this resolution and agreed that efforts to improve participation of MAG members at the district level is greatly needed. The committee could reach no consensus, however, that redrawing district medical society lines would achieve the desired effect.

Mr. Speaker, your Reference Committee approved the concept of Resolution 14, and recommends it be referred to the Council for study and appropriate action.

HOUSE OF DELEGATES ACTION—Approved the concept of Resolution 14 and referred it to Council for study and appropriate action.

Chairman Oliver expressed his appreciation to the members of the Reference Committee, Mr. Winston Huff, MAG legal counsel, and the MAG staff for their time and effort in the preparation of this report.

The Speaker expressed his thanks to the Chairman and each member of the reference committees for the work they had done on the reference committee reports.



The conclusion of the Annual Session is the oath of office taken by new officers (L-R) Fleming L. Jolley and Harrison J. Rogers of Atlanta, Dan Bateman, Albany, James H. Sullivan, Columbus, and Robert E. Perry of Brunswick. The outgoing President, David A. Wells of Dalton, hands the gavel to his successor, Dr. Jolley.



Election Results

Speaker Buchanan, having received the results of the election from the Tellers Committee, announced the election results as follows: President-Elect—Robert E. Perry, Jr.; Second Vice President—Milton I. Johnson, Jr.; AMA Delegate (Roger's seat) Harrison L. Rogers, Jr.; AMA Delegate (Bateman's seat) J. Daniel Bateman; AMA Alternate Delegate (Hammett's seat) H. Hilt Hammett; AMA Alternate Delegate (Moore's seat) W. W. Moore; Third District Councilor, John H. Robinson; Third District Vice Councilor, B. Lamar Pilcher.

The Speaker called for unfinished business and there was none. He asked for new business and none was reported.

Speaker Buchanan thanked all the members of the Reference Committee for their diligent work and the members of the House of Delegates for their close attention to the work of the House. He called for a motion to adjourn the Second Session of the MAG House of Delegates and on motion duly made and seconded, he declared the final session of the House of Delegates adjourned (4:07 p.m.) and immediately turned the meeting over to President David A. Wells for the closing General Session and Installation of Officers.

MAG Final General Session

Sunday, April 11, 1976

President Wells convened the final session of the 1976 Annual Session Business Meeting and expressed his appreciation to Drs. Buchanan and Galloway for their handling of the business of the House of Delegates.

Installation of Officers

Dr. Wells asked the incoming President, the other new officers, the AMA Delegates and Alternate Delegates, Councilors and Vice Councilors to assemble in front of the Speaker's platform for the purpose of taking the oath of office as follows:

President
Fleming L. Jolley, Atlanta (1977)
President-Elect
Robert E. Perry, Jr., Brunswick (1977)
First Vice President
James H. Sullivan, Columbus (1977)
Second Vice President
Milton I. Johnson, Macon (1977)
First District Councilor
Leon E. Curry, Metter (1979)
First District Vice Councilor
Charles R. Richardson, Statesboro (1979)
Second District Councilor
J. Daniel Bateman, Albany (1979)
Second District Vice Councilor
Sammie Dixon, Tifton (1979)
Third District Councilor
John H. Robinson, Americus (1979)
Third District Vice Councilor
B. Lamar Pilcher, Warner Robins (1979)
MAA Councilor
T. J. Anderson, Atlanta (1978)
J. Harold Harrison, Atlanta (1979)
Medical Association of Atlanta Vice Councilor
William D. Logan, Atlanta (1978)
William C. Waters, III, Atlanta (1979)
AMA Delegate
Harrison L. Rogers, Jr., Atlanta (1978)
J. Daniel Bateman, Albany (1978)
AMA Alternate Delegate
H. Hilt Hammett, LaGrange (1978)
W. W. Moore, Atlanta (1978)

President Wells administered the oath of office to the assembled new officers of MAG and declared each of the officers duly installed. Dr. Wells turned the gavel of leadership over to the incoming President, Fleming L. Jolley, who expressed his appreciation at the honor of being elected President for 1976-77 year. Dr. Jolley then presented to Dr. Wells the President's key and the bound volume of the issues of the *Journal of the Medical Association of Georgia* published during Dr. Wells' term of office.

Dr. Jolley announced the date and site of MAG Annual Session House of Delegates meeting for the following four year period:

1977—Macon, April 22, 23 and 24
1978—Augusta, April 21, 22 and 23
1979—Savannah, April 20, 21 and 22
1980—Atlanta (date and site not yet established).

President Jolley announced that the new MAG Council and Executive Committee would hold their organizational meeting immediately and entertain the motion for adjournment *sine die* of the 122nd Annual Session. The final session adjourned at 4:35 p.m.

Perry, Johnson Elected to MAG Offices



ROBERT E. PERRY of Brunswick was chosen by the House of Delegates at the April Annual Session as the 1976-1977 president-elect of the Medical Association of Georgia.

Dr. Perry, a member of MAG since 1945, has been the councilor from the Eighth District since 1970, and served a year previously as vice councilor. A leader on the local level, also, Dr. Perry served as secretary and president of the South Georgia Medical Society when his practice was in Valdosta, and after moving to Brunswick was president of the Glynn County Medical Society.

Dr. Perry was born December 4, 1921, in Sylvania, but his family moved to Savannah a year and a half later. He was graduated from Savannah High School in 1938 and went on to Clemson University in South Carolina.

In 1944, Dr. Perry received his medical degree from the Medical College of Georgia, where he was a member of Alpha Omega Alpha honorary medical society and Phi Rho Sigma social fraternity. His internship was served at Jefferson-Hilman Hospital in Birmingham, Ala. and he opened his practice in general medicine in Valdosta in 1945. In 1954, he began a residency in pathology at Duke University and came to Brunswick in 1958 as director of the pathology laboratory at Glynn-Brunswick Memorial Hospital, a position he holds to the present time.

Dr. Perry is certified by the American Board of Pathology in clinical pathology and pathological anatomy. He holds the position of vice speaker of the House of Delegates of the College of American Pathologists.

For three years, Dr. Perry was a city commissioner in Brunswick. He is a Rotarian, and past member of its Board of Governors, and a member of Christ Church on St. Simons.

Dr. Perry and his wife, Alice Carol, have five children and four grandchildren.

Second Vice President

Macon family physician Milton I. Johnson is the newly elected second vice president of the Association. The Medical College of Georgia graduate first

studied pharmacy and received the Merck Award for Outstanding Ability in Practical Pharmacy from the University of Georgia.

Dr. Johnson has been a delegate and alternate delegate, councilor and vice councilor from Bibb County. He has served as chief of the Department of General Practice of the Medical Center of Central Georgia. He is an active supporter of the Mercer University School of Medicine.

Dr. Johnson is a charter diplomate of the American Board of Family Practice and is vice president of the Georgia Academy of Family Physicians.

He is a Mason and Shriner, and his primary hobby is collection and restoration of antique cars. He and his wife, Joyce Ann McCowan Johnson, and three daughters are communicants of St. Paul's Episcopal Church.

CONTACT MCG PLACEMENT OFFICE FOR NURSES, TECHNOLOGISTS AND TEMPORARY HELP

The Medical College of Georgia has established a Placement Office to link health employers with students and graduates. An employer can list an opening with the Placement Office and qualified applicants will be referred by the placement counselor. A listing should include desired qualifications and a brief job description. The service is offered without charge to the employer or student. Also employers may request on-campus interviews which the office will arrange.

Of recent particular interest to the practicing physician is the primary care physician assistant. The physician assistant, working under the supervision of a physician, is trained to relieve the physician of certain basic tasks. The MCG program provides instruction in data collection for patient histories, numerous examinations and therapeutic procedures, laboratory tests, less complex diagnoses, patient education, and health facility management.

A physician interested in interviewing graduates of the MCG program may request referrals from the Placement Office. The staff will screen candidates in light of the physician's requested qualifications and type of practice. The best qualified candidates will be referred to the physician for consideration.

Health employers are invited to use the placement service when seeking applicants in those fields offered by MCG. Candidates are listed with the office in nursing, medical record administration, medical techonology, occupational therapy, physical therapy, radiologic technology, and medical illustration. Two new programs, physical therapy assistant and respiratory therapy, will graduate students in June of 1977.

The Placement Office offers two other services which may be of interest. One is the coordination of on-campus interviews with third-year medical students for hospitals. The second is listing of part-time and summer student employment opportunities. Employers are encouraged to use this listing service when seeking temporary help.

When placement service may prove helpful, contact the Placement Office, Medical College of Georgia, Augusta, Ga. 30902, (404) 828-3471. The office was created to serve the health employers of Georgia as well as MCG graduates.

ASK MEDICARE . . .

Q: Dr. Jones writes, "My bookkeeper wonders whether she should submit the original and the carbon copy of each Request for Payment."

A: No—please only send in the original. The copy is intended for the patient's records. Tearing the sheets apart is time consuming for us—and the extra weight may cost your office additional postage to mail.

Q: "How does Medicare arrive at the so-called prevailing rate?"

A: Various fees for a given procedure may be charged in an area, so determination of what charges are prevailing for any given period requires a statistical analysis of fees for that period. They are not averaged. Medicare goes well above the average, and takes as the prevailing rate the 75th percentile of the range of customary charges for a particular service in a locality.

Prevailing levels are updated at the beginning of the fiscal year following the calendar year in question.

president's letter

Dues Changes Strengthen the Association



THIS ISSUE OF YOUR JOURNAL reports the actions of your 1976 House of Delegates. Considerable debate was given, particularly, to issues of dues increase, reorganization, sliding scale of dues, and the Scientific Session. The reference committees functioned quite well and my commendations go out to all who participated. The entire membership should be proud of their representation at the session.

By its action, the House projects a viable organization interested in the many on-going programs of service for its membership. This is to be accomplished on a balanced budget.

The sliding dues scale provides an incentive to the young physician starting in practice for the first time to join the organization, and aids our senior members with a descending scale of dues from their 66th birthday to life membership at 70.

The annual dues of $225 reflects an independence from federal grant support of certain staff positions and should be expected to establish the services requested by the membership in an effective and meritorious manner.

A more careful reading of these actions and with your personal input is essential in making this state medical society what you want it to be—a truly representative organization for all doctors of Georgia.

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Ownership of Medical Records

J. WINSTON HUFF, *Atlanta**

On several occasions over the past few years I have been asked about the ownership of a patient's medical records, including x-rays and laboratory reports.

There is no law or court decision in Georgia on the subject; and, strangely enough, very few court decisions elsewhere. However, the few cases which do exist indicate that these records belong to the physician and not the patient.

A New York court was faced with a novel situation involving ownership of medical records. A physician provided in his will that all of his professional records be burned. After his death several patients wanted their records to be transferred to their new physician and sued to prevent the destruction of the records. The New York Court held that as a matter of law the records belonged to the doctor's estate and not to his patients. However, the court then turned to the AMA *Principles of Medical Ethics* and certain opinions of the Judicial Council deciding that a physician is ethically obligated to cooperate with and turn over records to a physician who succeeds him in caring for the patient. The court held that while the records belong to the deceased physician's estate, the ethically improper provisions of the will requiring destruction would be ignored in the interest of public policy, thus permitting the records to be transferred to the new attending physician. The court further said that these records must be turned over to the succeeding physician and not to the patient, since the physician was the person professionally qualified to read and interpret the records.

A Michigan case involving ownership of records arose out of an occupational injury. In the course of treating the injured workman, the physician made certain x-rays. The patient's employer refused to pay the physician for his services unless the x-rays he had made were turned over to the employer. The physician refused and sued for his fee. The Supreme Court of Michigan held in favor of the physician. The court stated that in the absence of an agreement to the contrary, x-ray negatives are the property of the physician who made them incident to the care of the patient. The court determined, in reaching this result, that the x-rays were of extraordinary value to the physician and really meaningless to the layman.

The opinions of the AMA Judicial Council support this view. An opinion under Section 9 of the *Principles of Medical Ethics* states that "The Principles neither intend nor require that a physician give a copy of his records to his patient. These records are primarily the physician's own records compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment."

Based on the quoted decisions I conclude that, until we have legislation or a court decision in Georgia to the contrary, the attending physician should assume that he owns his records and act accordingly. ■

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer and Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Bldg., 35 Broad St., Atlanta, Ga. 30303.

I've told this before . . . .

(Ed. note: A new contributor to our feature page writes this month of his experience with myocardial infarction—unexpected, and undiagnosed for several days. An advocator of physical fitness, Dr. Kellum made discoveries about his "behavior type" which he feels may have contributed to his heart disease.)

I Played Golf, Two Successive Days, With Acute M.I.

IT SOUNDS CRAZY, but it is true. All of this happened in April of 1975. I had a very vivid dream Friday night: A beautiful young lady, but very sad-faced, descended from the sky to the ground wearing a long, white, flowing robe, illuminated by a giant, brilliant, search light. As she approached, I noticed that she had a black badge across her waist, with these letters: DEATH. I made a VIOLENT protest and then I awakened. I slept very little the rest of that night. The next day, while playing golf, I could not concentrate, for thinking about this dream—my score was worse than usual.

On Saturday morning, I began to have some indigestion, while at my office. It was not substernal; it was in my stomach. I attributed this to aspirin that I had been taking, for arthritis of my knee. I took Gelusil for this, but with no relief. That afternoon, I played 18 holes of golf, and pulled a cart. Sunday morning, the indigestion was worse. I added Donnatal® and Gaviscon® to my regimen, but, again, with no relief. I played golf, 18 holes, that afternoon, and pulled a cart, as usual. On Monday, I continued to have the indigestion. I began drinking milk, along with my other medication, to seek relief, but this did no good.

Tuesday, the indigestion had left, but I began to run a temperature of 100 to 101 degrees, and I thought that I had asymptomatic flu; so I stayed in the house, for the next week, with a daily fever, as above. I was ambulatory over the house, and I felt fine, except having a fever. On the seventh day of this fever, two of my doctor friends paid me a social call. They wanted to know why the hell I had not been at work. (It had been a rare occasion, during the past 35 years, that I had missed a day from work, due to illness.) They noticed that I was a little short of breath, when I talked; I had not noticed this. They suggested that I have a chest x-ray; that I may have a small area of central pneumonia. I drove myself to the local hospital, and had a chest x-ray, and the radiologist told me that I had congestive heart failure, this shook me up. I then had an EKG, and I was told that I had an acute inferior wall infarction!

For a few minutes I felt as if a ton of bricks had fallen on top of my head. Why should this happen to me? I thought this only happened to patients. My wife then drove me to a nearby University Hospital. I checked in under the care of an eminent cardiologist who has treated such VIP's in the past as LBJ, and whose textbook on cardiology is used in most medical schools.

When I entered the hospital, my doctor started things off right. He brought in the prettiest nurse in the hospital, and told me; "This young lady is in charge of this floor, and if you need anything, call her." I called her frequently. I was in the hospital for a week, ambulatory in my room. I was treated with Lanoxin® and Lasix® and radio-telemetry, monitoring. After one week in the hospital, I was sent home, to stay in the house for two months!

This was the worse part of it all. I sat in my den, and looked at soap operas until I became disenchanted, forever, with TV. I listened to my wife talk to her friends over the telephone, about recipes for upside-down cake, how to take up a hem, let out a hem, and who was thought to be currently pregnant. However, it

gave me a chance to catch upon my medical journals and hospital charts. I also read the *Atlanta Journal* and *The Atlanta Constitution* thoroughly. I would read, and then, re-read them, again, and then, I would even read the want-ads. Heretofore, I had been getting up at 6 a.m. looking at the headlines of the paper, on my way to my car, eating breakfast at the hospital, making rounds before surgery, and then to my office on TIME. I rarely saw my wife, except at supper time.

Why should this happen to me? My heredity is noted for longevity. I keep my weight normal. I eat a low cholesterol diet. I played 18 holes of golf, and pulled a cart three times a week. I rode my bicycle two miles a day. I have never smoked or drank coffee. (I do drink an occasional jigger of Scotch and, a big Bud, when I have played golf on a hot, Georgia summer afternoon.) I am a young 65, have all my hair, and none is gray. Semi-annual physical examinations and stress EKGs have always been negative. Cholesterol triglycerides and T-4's have always been in normal range. Lipoprotein phenotype was normal class.

While I was laid up, a doctor friend brought me this book to read, "Type A Behavior and Your Heart." This was written by Dr. Meyer Friedman and Dr. Ray H. Rosenman, cardiologists, Fawcett Publications, Inc., Greenwich, Connecticut.

What is Type A behavior? I will quote from their book: "It is a special, well defined pattern, marked by a compelling sense of time urgency—hurry sickness, aggressiveness and competitiveness, usually combined with a certain amount of repressed hostility. Type A's engage in a chronic, continuous struggle against circumstances, against others, and against themselves. The behavior pattern is common among hard driving, and successful business men and executives, but is just as likely to be found in factory workers, accountants, and even housewives. About half of all of the medical males, and a growing percentage of females, are more or less confirmed Type A's. Type A's look at their wrist watches and desk calendars 25 to 50 times a day. They are always in a hurry, even when hurry is not indicated."

The authors of this book contend Type A behavior causes an increased endogenous deposition of cholesterol in the blood vessels, which they contend is the cause of atherosclerosis and coronary heart disease.

I have decided that I am a Type A behavior personality. I have always been a hard working, hard driving individual, with energy to burn; I really had to. I sent one son through medical school, another through law school, and the third son is enrolled in medical school now. (I calculated that we needed, at least, one lawyer in the family, to protect us from other lawyers.)

I highly recommend to every doctor, regardless of his specialty, to read this book. It can be purchased at a bookstand, in paperback, for $1.50. It may help you to prevent a myocardial infarction, as I had, and it will aid you in counseling your patients. Type B behavior is a moderate, which everyone should strive to be. A Type C is lazy as hell.

As I stated above, I am back at work (June, 1975) but striving to get in the Type B class. Instead of working 25 hours a day, I now work only 24 hours. I keep my wrist watch in my pocket, and I have done away with my desk calendar. I have resumed golf (October, 1975) three times a week, ride my bicycle, and swim.

In conclusion, if and when I have another coronary, I trust that it will, again, be painless, occurring at age 80 or better and precipitated by an altercation with a young, jealous husband.

I recommend to anyone who has indigestion that does not respond to any kind of medication, and persists, that he not walk, but jog to the nearest facility and have a stat EKG!

In all seriousness, acute M.I. is a most serious, medical emergency—50 percent die within the first hour, and those who survive have a 30 percent chance of a recurrence in the next five years with a 40 percent mortality.

I'VE TOLD THIS BEFORE / Continued

I still believe in physical fitness, and exercise; it developed good collateral circulation in my heart muscle and saved my life. As of now, no one has all of the answers to atherosclerosis and coronary heart disease.

The dream I had in April still haunts me! I wonder how Freud would have interpreted it?

J. Morgan Kellum, M.D.
Thomaston, Georgia 30286

EMORY RESEARCH MAY IMPROVE EARLY TESTICULAR CANCER DIAGNOSIS

An Emory group looking for a better way to diagnose early cancer of the testicle has reported promising results using a new type of blood test.

The test is for two "markers" frequently seen in testicular cancers. These antigens are called AFP (alpha fetoprotein) and HCG (human chorionic gonadotropin).

It was found that 73 percent of patients with active malignancies of the testicle had elevated amounts of HCG or AFP in their blood. Only three percent of patients with no malignancy had elevated HCG or AFP.

"The findings suggest that HCG and AFP are sensitive and specific tests for the diagnosis and evaluation of patients with testicular cancer," said Dr. Melvin R. Moore, assistant professor of medicine at the Emory medical school, in a paper presented at the annual meeting of the American Society of Clinical Oncology in Toronto, Canada, May 4, 1976.

The Emory research is sponsored by grants from the National Institutes of Health. Dr. Charles L. Vogel, formerly chief investigator, resigned from the Emory faculty last year. Others involved in the research include Dr. Thomas A. Waldmann of the National Cancer Institute, Dr. Kenneth N. Walton of the Emory Division of Urologic Surgery, and Patricia Counts, R.N.

Dr. Moore said blood serum from patients with testicular masses or with proven testicular cancer is tested for the two tumor markers, HCG and AFP. Results are then correlated with clinical findings to determine the value of the tumor markers in establishing a diagnosis of testicular cancer and in following patients with the disease to learn if there is a recurrence.

"In spite of the relative rarity of this form of cancer," Dr. Moore said, "we have been able to test over 50 patients with the cooperation of the Atlanta urologic community."

Dr. Moore and his Emory colleagues have received a new grant of $25,442 from NIH to continue the study until March 1977.

PROJECT BRINGS MEDICAL STUDENTS TO ATLANTA FOR SUMMER COMMUNITY HEALTH JOBS

Through a unique program offered by the Atlanta Urban Corps, medical students will no longer have to depend on reports and surveys to learn the problems of community medicine and the complexities of the health services delivery system.

The Medical Internship Project (MIP) beginning its third summer, offers first, second and third year medical students from medical schools throughout the nation the opportunity to work in supervised, project-oriented community health job settings throughout metropolitan Atlanta.

Jointly funded with a stipend grant from the Jessie Smith Noyes Foundation of New York, federal work-study funds, and the shares paid by the participating agencies, the student interns receive a $1,200 stipend.

Previous MIP interns have served the health needs of handicapped children and adults; counseled and helped deliver clinical care in alcoholism, family planning, and hypertension programs; surveyed the availability of rural health care; and assisted planners in developing programs for the elderly.

With the assistance of Drs. Henry Kahn and Dan Blumenthal of Emory's Preventative Medicine and Community Health Care Department, weekly seminars will be conducted as a vital adjunct to the internship experience. The seminars will deal with such areas as the community mental health care concept, health care models in other countries, and the current status of health planning legislation. Health professionals in these respective fields as well as clients and patients served by local health agencies will serve as resource persons for the seminars. Many of these sessions will be held at actual health care delivery sites.

According to project director Lonni Ann Fredman, "The MIP project works on a number of levels simultaneously. Besides providing needed manpower to local health agencies, the program directly exposes medical students to the problems and challenges that exist in the community health care area. By involving them in the actual solutions to those community health concerns, the program complements their medical education in a very vital and integrative way."

For further information, call Ms. Fredman at (404) 658-3558.

One copy of the 1976 Roster will be mailed to each active member of the Medical Association with his August issue of the **Journal.**

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available by advanced order for $5 a copy. Non-members will pay $10 for the first and every additional copy.

Checks should be made payable to the Medical Association of Georgia. Copies that have been ordered in advance will be mailed out at the end of August.

1976 ROSTER ORDER FORM

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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Baker, J. Jay, MAA—Act—On
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X-Ray Dept., 80 Butler St., S.E., Atlanta 30303

Cadier, Thomas R., MAA—A
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Carspecken, Harold Hutson, DeKalb—Act—PL
755 Columbia Dr., Decatur 30030

Cox, George W., MAA—Act—R
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Dimou, Theofanis G., Floyd-Polk-Chat.—Act—FP
Floyd Hospital, Rome 30161

Douglas, John S., Jr., DeKalb—Act—C
Emory Univ. Clinic, Atlanta 30322

Dourron, Maria L., DeKalb—Act—ObG
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Earley, William H., Hall—A—P
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P.O. Box 2395, Gainesville 30501

Etheredge, James Lee, Richmond—Act—Or
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Gibbon, John, Floyd-Polk-Chat.—Act—P
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Med. Center of Central Ga., Macon 31204

SOCIETIES

The **Bibb County Medical Society** held a joint meeting with the Macon Bar Association in May to hear speaker Betty Jane Anderson, assistant general counsel to the American Medical Association. The June 2 meeting featured two political candidates, C. C. Moreland, M.D., of Monroe who is running for the 10th District congressional seat, and J. Roy Rowland, M.D. of Dublin who hopes to win election to the Georgia General Assembly.

Several members of the **Cobb County Medical Society** Athletic Committee conducted physical examinations for 40 mentally retarded youngsters recently who competed in the county "special olympics." Helping with the examinations were Drs. J. S. Bethea, committee chairman, Gary Welliver, Robert Golden and Mitchell Jablow.

The Annual Sports Spectacular of the **Medical Association of Atlanta** was held in May with an audio visual program on sky diving, hang gliding and body surfing.

The **Upson County Medical Society,** through Warren Patrick, congratulated the Upson County Hospital on

25 years of service to the community in ceremonies April 23.

PERSONALS

First District

John D. Northup of Savannah spoke on the diagnosis and treatment of stomach disorders to a May 12 Candler Associates educational meeting as part of National Hospital Week.

A newly-elected trustee of the University of the South in Sewanee, Tennessee is **Edwin C. Shepard** of Savannah. Dr. Shepard is a Medical College of Georgia alumnus and vice president of the Georgia Medical Society.

For a Savannah cardiology conference May 27, one of the guest speakers was **Joseph V. Morrison, Jr.** of Savannah. The conference was one of several coordinated by the Georgia Heart Association's nursing education committee.

Fourth District

Decatur physician **Robert M. Fine** has been certified in dermatopathology by the American Boards of Dermatology and Pathology. Dr. Fine recently attended the Noah Worcester Dermatological Association Meeting and participated in a panel on "The Histology and Growth Pattern of Malignant Melanoma." He is president of the Atlanta Dermatological Association.

R. Beauvais Randall was inducted as a Fellow of the American College of Cardiology during its annual scientific session and convocation in New Orleans, La. in April.

Thirty-eight years of obstetrical practice were highlighted by **Lawrence Matthews** in an *Atlanta Journal* feature story in April. Dr. Matthews told about the most unusual delivery of the over 12,000 in which he has participated. The patient arrived at the hospital in plenty of time, but an ice-covered slippery highway made it imposible for either the car or the patient to make it to the building . . . so Dr. Matthews delivered the baby in the car.

Fifth District

Fred Allman, Atlanta orthopedist, received the Anderson Award for excellence from the Alliance for Health, Physical Education and Recreation in April at the organization's annual meeting.

Nicholas E. Davies of Atlanta has begun a four year term as Governor for Georgia of the American College of Physicians, succeeding **Edwin C. Evans.** Another Atlantan, **David E. Dalrymple** was inducted as a Fellow of the College during the April meeting in Philadelphia.

Bob G. Lanier has been appointed by the Fulton County Grand Jury to a four year term on the Board of Health. Dr. Lanier was graduated from the Medical College of Georgia in 1962 and did his residency at the Mayo Graduate School.

Ophthalmologist **Jess C. Lester** spoke to the College Park Chapter of the American Association of Retired Persons recently, and answered their questions on eye diseases and problems.

J. Willis Hurst of Emory University will give the

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keynote address of the 42nd Annual Scientific Assembly of the American College of Chest Physicians when they meet in Atlanta in October.

Sixth District

Ronald A. Freeman of Macon has become board certified in plastic and reconstructive surgery after passing board examinations in May.

James Watts Lipscomb of Forest Park has been appointed by Gov. George Busbee to the State Board of Medical Examiners, replacing Benjamin Jenkins, Jr. of Newnan. Dr. Lipscomb is a graduate of the University of Virginia School of Medicine and currently has a practice in internal medicine in Clayton County. Reappointed to the Board were Drs. Hassie H. Trimble of Moultrie, **Albert M. Deal** of Statesboro and **Robert E. Thompson** of Toccoa.

Jack F. Menendez, president of the Bibb County Medical Society, is the new medical director of the Georgia Medical Care Foundation.

Beverly W. Forester discussed and debated the current malpractice situation with lawyers in April in observance fo the 28th Annual Law Day at the Mercer Law School.

Eighth District

Waycross physician **Edward B. Waxler** was inducted as a Fellow of the American College of Physicians in April.

Tenth District

W. B. Strong of the Medical College of Georgia lectured recently at the ninth annual scientific sessions of the Society of Pediatrics of Panama.

J. Graham Smith, Dermatology Department chairman at MCG, is the new secretary of the American Dermatological Association, a post he will hold for five years.

Paul R. Dyken recently served as a visiting professor in pediatric neurology for Emory University.

DEATHS

F. Bert Brown

The first orthopedic surgeon in Savannah, F. Bert Brown, 75, died April 20 after a long illness.

Dr. Brown was born in Sharon, but moved to Savannah in 1938. He was a graduate of the University of Georgia, where he was a member of Phi Delta Theta, and the Medical College of Georgia. Additional training was taken at Massachusetts General Hospital and Children's Hospital of Boston.

Dr. Brown was a past president of the Georgia Orthopedic Society and was a member of Wesley Monumental United Methodist Church.

Survivors include his widow, Mrs. Edith Pilcher Brown of Savannah; sister, Miss Gladys A. Brown of Sharon; brother, Arthur D. Brown of Sharon.

James Loy Carpenter, Jr.

Marietta psychiatrist James Loy Carpenter, Jr., died May 1. He was 41 years old. Dr. Carpenter was graduated from Emory University Medical School, served a rotating internship at Macon Hospital, and a residency at Emory. He was associated with the Georgia Regional Hospital and was a member of the Sandy Springs United Methodist Church.

Survivors of Dr. Carpenter include his widow, Mrs. Paula Huffstutler Carpenter; daughter, Jamie Donlyn Carpenter; mother, Mrs. Loy Carpenter; sisters, Mrs. Ross Howard of Marietta and Mrs. Lansing Lee of Augusta; aunt, Margaret Carpenter of Marietta.

Charles B. Fulghum

Charles B. Fulghum, 69, died May 7 in Milledgeville where he had lived 44 years and was a member of the Baldwin County Hospital staff. Dr. Fulgham was a Fellow of the American College of Physicians and Surgeons for 29 years.

The Macon native was graduated from Mercer University and the Medical College of Georgia. He interned at the U.S. Navy Hospital in Washington, D.C. and the Henry Ford Hospital in Dearborn, Mich.

Survivors include his widow, Mrs. Martha Carpenter Fulghum of Milledgeville; sons, Charles Fulghum of Springfield and Dr. David Fulghum of Bradenton, Fla.; brother, James Fulghum of Roanoke, Va.

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Georgia physicians who played a significant role in our nation's history



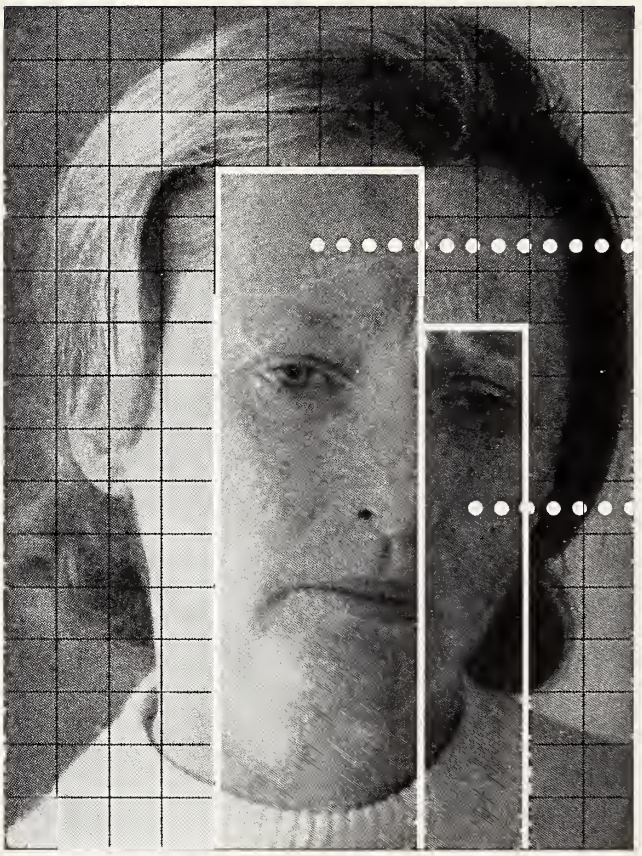
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THE COVER

Georgia can be proud of two physicians who influenced the course of history. The July bicentennial issue reviews the lives of Dr. Lyman Hall, signer of the Declaration of Independence, and Dr. Crawford W. Long, the first to use ether as an anesthetic in surgery. Also in this issue is an historical article on an early yellow fever epidemic in Georgia. Cover by Bob Hamill, Atlanta.

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Dr. Lyman Hall, Signer of the Declaration of Independence

W. TALBERT WILLIAMS, M.D., *Smyrna**

FIVE SIGNERS of the Declaration of Independence were physicians, Benjamin Rush of Pennsylvania, Josiah Bartlett and Matthew Thornton of New Hampshire, Oliver Wolcott of Connecticut, and not the least of these, Lyman Hall of Georgia.

Lyman Hall was born in Wallingford, Connecticut, April 12, 1724. His original ancestor in this country was Captain John Hall who was born in England in 1605. He came to America from Coventry, Warwick, on the good ship *Griffith* in 1633. He lived for a while in Boston, later moved to New Haven, and eventually settled in Wallingford, Connecticut about 1670.

Lyman Hall grew up in an atmosphere of rugged independence and definite opinions on the subject of individual freedom as his Puritan ancestors were keenly sensitive to any infringement of their religious or civil rights. It was more than mere coincidence that his birthplace was the one town in Connecticut above all others to be noted for its independence and religious tolerance. Wallingford was the first town in Connecticut to be settled under guarantee to the Church of absolute independence and freedom from Church interference in political matters. They were independent thinkers who firmly believed in honesty and integrity.

Graduation and the Ministry

In 1747, Dr. Hall graduated from Yale with an A.B. degree in a class of 28. Three other Yale students at the time signed the Declaration of Independence. The other signer in his class was Oliver Wolcott of Litchfield, Connecticut, who also had a medical degree. Hall then became a Congregationalist minister, studying under the Reverend Samuel Hall, his uncle. He had differences with his congregation and left the ministry, next working as a teacher while studying medicine under a local physician, the common practice at that time. He was successful in his medical studies and began practicing in Wallingford.

As a pet colony of England, Georgia was reluctant to enter the revolution until Dr. Hall lit the fires for freedom.

Lyman Hall was twice married, first while serving as a minister in Fairfield to Abigail Burr on May 20, 1752. Her grandfather, Judge Peter Burr, was an important person in colonial affairs, and, among many positions held, was Chief Judge of the Superior Court. Their marriage was short-lived. Abigail Burr Hall died July 8, 1753 at the tender age of 24. His second marriage was to Mary Osborne, also of Fairfield. She was a descendant of the first settlers of Hartford, Connecticut.

Moving South

During 1757, at the age of 33, Dr. Hall decided to cast his lot with a group of Puritans who were settled in South Carolina on the left bank of the Ashley River, not many miles from Charleston. Their forebears had migrated there in 1697 from Massachusetts, and called their new home Dorchester, in honor of Dorchester, England. There they were not completely happy, partly because of it "being also a very sickly part of the country" due to the swampland and resulting malaria. After preliminary investigations, he and others moved to the Midway district of Georgia. It received its name from the fact that it was midway between Savannah and

* Chairman of the Medical Association of Georgia Bicentennial Committee. Dr. Williams is in practice at 696 Concord Road, S.E., Smyrna, Georgia 30080.

Darien (some books say midway between the Savannah and Altamaha rivers). Midway was located on one of the oldest roads in the state, having been laid out by General Oglethorpe to connect Savannah and the Scotch settlement at Darien. It was built by Lt. Hugh MaKay, with Chief Tomochichi furnishing guides to aid the white men in blazing their trail over the marshes and swamps. Near Midway, he managed his plantation, now known as Hall's Knoll. He also moved to Sunbury and helped settle that community in 1758. It became an important port. Indigo and rice were cultivated extensively. His practice flourished as he ministered to the slaves and less fortunate whites as well as Midway's well-to-do.

Influencing Button Gwinnett

At the Midway settlement a warm friendship between Lyman Hall and Button Gwinnett developed. There is good reason to believe that it was the former's influence that germinated the intensity of spirit which was so manifest in the patriot Gwinnett. Hall, in a letter to Roger Sherman, wrote, "Gwinnett is, if possible, a Whig to excess." Gwinnett lived in nearby St. Catherine's Island. It was Lyman Hall's lot to care for Button Gwinnett's knee wound following his duel in 1777 with General McIntosh. Button Gwinnett unfortunately died. Gwinnett wrote and spoke but seldom and his signatures today are among the rarest of the signers. As much as $51,000 has been paid for his signature!

Midway was in the Parish of St. John. In a comparatively short time the industrious people controlled nearly one-third of the wealth of the entire province of Georgia, so it is no wonder that at the beginning of the Revolution the Parish of St. John maintained an influence in colonial affairs remarkable for so new a settlement. It became known as the Southern Cradle of Liberty.

Georgia's Reluctance

It must be remembered that Georgia occupied a peculiar position among her sister colonies. The care of the Crown had been a particularly kindly one. Large sums for the extension of silk culture and generous bounties for other purposes had been sent over by the mother country. As a natural consequence, there existed a great difference of opinion immediately preceding the open rupture between England and America. Frequently father and son were on opposite sides.

When St. John's Parish learned that the First Continental Congress had failed to place Georgia in line with the other 12 colonies, they, under the leadership of Dr. Lyman Hall, resolved "to exert themselves to the utmost and to make every sacrifice that men impressed with the strongest sense of their rights and liberty, and warmed with the most benevolent feelings for their oppressed brethren, can make to stand firmly or fall gloriously in the common cause." Unable to gain support from the rest of Georgia and declined by South Carolina, they elected Dr. Hall on March 21, 1775 to represent them in the Second Continental Congress.

One of his earlier biographers says of him, "He was six feet high, with easy and polite manners and deportment." Another historian writes concerning this period, "On the Revolutionary alters erected within the Midway District were the fires of resistance to the dominion of England earliest kindled, and of all the patriots of the uncompromising community, Lyman Hall by his counsel, exhortation and determined spirit added stoutest fuel to the flames."

When he left for Congress, he and the St. John's District sent 160 barrels of rice and 50 pounds sterling as a present to the suffering Massachusetts patriots. Arriving in Philadelphia on horseback, he presented his credentials to Congress on May 13, 1775 and was unanimously admitted as a delegate from the Parish of St. John, in the Colony of Georgia, subject to such regulations as Congress should determine. Until his state was fully represented, Dr. Hall declined to vote upon such questions which were to be decided by a vote of the colonies. He declared "that the example which had been shown by the parish he represented would be speedily followed and that the representation of Georgia would soon be complete." This prediction came to pass within a very few months and Georgia joined the confederated colonies. He returned and signed the Declaration of Independence along with George Walton and Button Gwinnett on August 2, 1776.

The influence of Dr. Lyman Hall cannot be overestimated. On May 2, 1776, John Adams noted in his autobiography that "Lyman Hall . . . appears as a delegate from Georgia, intelligent and spirited, making a powerful addition to our phalanx."

Governor of Georgia

After the fall of Savannah, Georgia's entire coastal region passed into the hands of the British, and Dr. Hall's residence and plantation were destroyed. He removed his family to the North until Savannah was evacuated by the British in 1782. In 1783 he was elected the first full term Governor of the new state. Insights into Dr. Hall's character can be gained from this paragraph taken from his speech of acceptance: "The early and decided part which I took in the cause of America originated from a full conviction of the justice and rectitude of the cause we engaged, has uniformly continued as the principle of my heart, and I trust will to the last moments of my life."

While Governor, he was instrumental in establish-

ing the first land grant state university in America, called Franklin College for Benjamin Franklin, now known as the University of Georgia. He also settled disputes over the northern boundary of Georgia and consummated treaties with the Indian nations. He was responsible for establishing an academy in Augusta, the Academy of Richmond County.

Following his years of service as Governor, he resumed his medical practice in Savannah, holding but one public office, that of Judge of the Inferior Court of Chatham County.

In 1790 he purchased a fine plantation in Burke County near Shell Bluff on the Savannah River. He lived only a few months there, dying October 19, 1790, followed shortly by his wife. His only child, a son, died without leaving offspring. Hall was buried in a brick vault on a bluff overlooking the Savannah River. In 1857 his body was removed to Augusta by Dr. William D'Antignac and placed beside George Walton's body beneath a large obelisk monument erected by patriotic citizens to the Georgia signers. The location of Button Gwinnett's grave is unknown.

The marble slab marking the vault at Shell Bluff was sent to the town authorities of Wallingford, Connecticut who display it prominently with these words, "This marks the beginning of life for one of the living stones which, coming from this town, formed the foundation of our Republic."

The efforts of the people of the Midway community resulted in the county being named "Liberty" and, of course, Hall County was named for Dr. Lyman Hall.

Breathes there a man, with soul so dead,
Who never to himself hath said,
This is my own, my native land!
Sir Walter Scott
The Lay of the Last Minstrel

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GEORGIA HEART ANNUAL MEETING IN ATLANTA

The Georgia Heart Association's 28th Annual Meeting and Scientific Sessions will be Friday through Sunday, September 17-19 at the DeSoto Hilton Hotel in Savannah.

Scientific Sessions for Physicians and a dinner-dance Friday night will be presented in honor of Eugene A. Stead, Jr., M.D., a native Atlantan who is professor of medicine at Duke University. Dr. Stead is an alumnus of Emory University School of Medicine and served as dean of the school in 1942-46. He has been at Duke since 1947, serving for 20 years as chairman of the department of medicine and physician-in-chief at Duke University.

The Sessions for Physicians are part of a weekend of activity for GHA, including sessions for nurses, dietitians and nutritionists as well as a general session on research and the installation of new association officers.

Speakers for the physicians Friday morning will be Norman E. Shumway, M.D., Ph.D., chairman of the department of cardiovascular surgery at Stanford University, "Coronary By-Pass Surgery"; and R. Bruce Logue, M.D., professor of medicine (cardiology) at Emory University, "Medical Management of Angina and Coronary Artery Disease."

Dr. Shumway will speak again Saturday morning on "Heterograft Valve," and H. J. C. Swan, M.D., Ph.D., will discuss "Ventricular Unloading—A New Dimension in the Treatment of Heart Failure." Dr. Swan is director of the department of cardiology at Cedars-Sinai Medical Center and professor of medicine at the University of California at Los Angeles.

Sunday morning speakers will be Laurence E. Earley, M.D., professor and chairman of the Department of Medicine at the University of Texas Health Science Center at San Antonio, "Vascular Alterations in Congestive Heart Failure"; and James V. Warren, M.D., professor of medicine and chairman of the department of medicine at Ohio State University College of Medicine, Columbus, Ohio, "Sudden Death."

Dr. Stead will be moderator of a panel discussion Friday afternoon and will participate in one of five small group discussions to be presented Saturday and repeated Sunday. His topic is "Congestive Heart Failure."

During the Annual Meeting Luncheon at noon Friday, Joseph A. Wilber, M.D. of Atlanta will be installed as president of GHA. Dr. Wilber is supervisor of the adult health section of the Georgia Department of Human Resources.

The General Session, entitled "Cardiovascular Research Frontiers," is scheduled for Friday afternoon. It is designed to appeal to medical and non-medical volunteers.

Speakers will be James V. Warren, M.D.; Curtis G. Hames, M.D., Claxton; and Robert L. DeHaan, Ph.D., Neil C. Moran, M.D. and J. Willis Hurst, M.D., all of Atlanta.

Registration forms for the sessions are available from the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta 30324.

Crawford Williamson Long: His Life and His Discovery

When reviewing the history of medicine in Georgia, two names immediately come to mind: Lyman Hall, who signed the Declaration of Independence and was the first full term governor of the new state; and Crawford W. Long, the first to use ether as an anesthetic in surgery. It is Long's statue, along with that of Alexander Stephens, vice president of the Confederacy, which stands in Statuary Hall in Washington, D.C. as a representative of Georgia's greatest citizens.

The significance of Long's discovery is far reaching, for without a satisfactory means of producing a relaxed and unconscious patient, surgery as a science and art could not advance. Surgeons of the time could deal only with a limited number of disorders and diseases; explorations of the inner cavities of the body were impossible. Any incision was so painful to the patient that the surgeon had to work quickly before he died from shock and loss of blood. The patient had to be strapped down or held by several assistants, with the risk that his movements might cause the knife to slip. Rooms for surgery frequently were placed on the top floor of hospitals so that the screams of the patients would not disturb others any more than necessary.

If the surgeon could not eliminate the pain, at least he could be quick. A "good" doctor could perform an amputation in minutes. One Scottish physician of the early 19th century advised doctors to make rapid skin incisions and to become ambidextrous.

The Search for Pain Killers

Throughout history various substances had been tried to reduce a patient's sensations of pain. Alcohol was a favorite, or mandragora. Hemp, or marijuana, was used by the Chinese. Medieval physicians prepared "hypnotic" sponges filled with opium, hemlock, mandragora and other substances, which were pressed to the patient's nostrils until he was unconscious. Opium became the only reliable means of deadening pain before the discovery of ether.



A statue of Crawford Long stands in the Madison County Courthouse square in Danielsville. Inscribed with Long's words, "My profession is to me a ministry from God," the statue is a replica of one which has been placed in Washington, D.C.

Ether itself was mentioned in writings of the 16th century. Humphry Davy, an English physician in 1799, inhaled nitrous oxide gas, or "laughing gas" and realized its potential for surgery. Then Henry Hill Hickman, disturbed by the suffering of patients undergoing surgery, was the first to use carbon dioxide as an anesthetic. Mesmerism, or hypnosis, was experimented with during the same years that ether was being tried.

A world of possibilities was opened for physicians when Crawford Long gave a towel soaked with ether

to James Venable on March 30, 1842, then painlessly cut a sebaceous cyst from his neck.

The circumstances of Long's life, the thorough training he had for the times, and his isolated, country practice influenced his making the discovery and the resulting controversy for that honor.

Long's Early Years

Long was born in Danielsville, Georgia on November 1, 1815. His grandfather, Samuel Long, arrived in America from Ulster, Ireland with his two brothers in 1761. The Long family was prosperous in Ireland, but they rebelled against the absentee landlord who saw their prosperity as a reason to raise their rent. All three brothers fought in the Revolutionary War, then Samuel came to Georgia in 1791. His son James, Crawford's father, had been born in Carlisle, Pennsylvania in 1781. James became a leading citizen in the new town of Danielsville, its first postmaster, a clerk of court, owning the first store and flour mill, the first to hold a liquor license. He invested in the Georgia Railroad, founded the Danielsville Academy, and served in the state Senate.

He named his son, born in 1815, for his closest friend, William H. Crawford of Georgia, a secretary of war and minister to France who was defeated by John Quincy Adams in his race for the Presidency of the United States.

As James Long knew the president of nearby Franklin College in Athens (the University of Georgia), Crawford entered at an early age, 14, and was graduated in 1835. Tradition says his roommate at school was Alexander Stephens, later to be Governor of Georgia and Vice President of the Confederacy. We do know that the years each spent at Franklin College overlapped.

At 19, Long was considered too young to begin the study of medicine, in which he had become interested while working in pharmacies in Athens. So for a year, he stayed in Danielsville and was principal of the academy. He began to "read" medicine under the tutorship of Dr. George R. Grant of Jefferson, occasionally helping him with his office practice.

Two Medical Schools

In 1836 he decided to attend the medical school at Transylvania University in Lexington, Kentucky and in 1838 transferred to the University of Pennsylvania. These two schools were the oldest medical schools in the country and were highly respected. Among the distinguished professors at the University of Pennsylvania was George B. Wood who edited the *United States Dispensatory,* and helped shape the views of the whole profession on ethics and practice. Biographer Frank Kells Boland, M.D. surmises that Wood's strong feelings toward the premature reporting of findings influenced Long, and contributed to his delay in reporting his use of ether.



The graves of Long's parents, Elizabeth Ware Long and James Long, rest in a small Danielsville cemetery next to the Church of God.

Long first learned of the effects of nitrous oxide gas while in college in Philadelphia. It was tried by the students in his boarding house for fun and entertainment, not for scientific experimentation.

After graduation from Pennsylvania in 1839, Long went to New York for further study, observing and helping in the hospitals for 18 months. He finally returned to Georgia in 1841, now 25 years old, and bought the practice of his former preceptor, Dr. Grant, in Jefferson, a town of a few hundred people. His practice was carried on by horseback, traveling to his patients scattered around the countryside, or seeing those who could reach him in town at his office on the square.

In larger towns the residents were aware of ether, as "laughing gas" demonstrations were given in a sideshow, carnival atmosphere. Long learned of ether in college and introduced his friends in Jefferson to its effects. He began to observe that the bumps and bruises received while under the influence of ether were not felt, and were noticed only after its effects had worn off. He began to give some thought to its use in surgery.

The First Experiment

The opportunity to try his theory arose when a

younger friend, James Venable, a student at the academy, sought his help in treatment of what probably were sebaceous cysts in the back of his neck. Venable put off having the painful procedure of cutting them out done, until Long suggested that ether be used. Venable had participated in the ether parties and was familiar with its effects. He agreed, and after classes on March 30, 1842, the procedure was done. Venable breathed the ether from a towel, while several witnesses, including the principal of the academy, watched Long remove one cyst.

During the next four years, his use of ether was repeated from time to time when appropriate cases came up in his varied practice. The toes of a young boy, cysts on a woman, fingers burned on another boy, were removed. Frequently ether was used for one incision, and not for the second to prove its effectiveness in blocking the sensation of pain. There was a danger at one point to Long's reputation, as some of the townspeople spread rumors that he was a mad doctor who would put people to sleep and then carve them up.

For a number of reasons, such as the busy demands of his practice, or his reluctance to report his findings until further cases were tried, Long did not publish notices of his work. This was unfortunate, and he was to spend many years trying to earn credit for his discovery.

Morton Makes His Claims

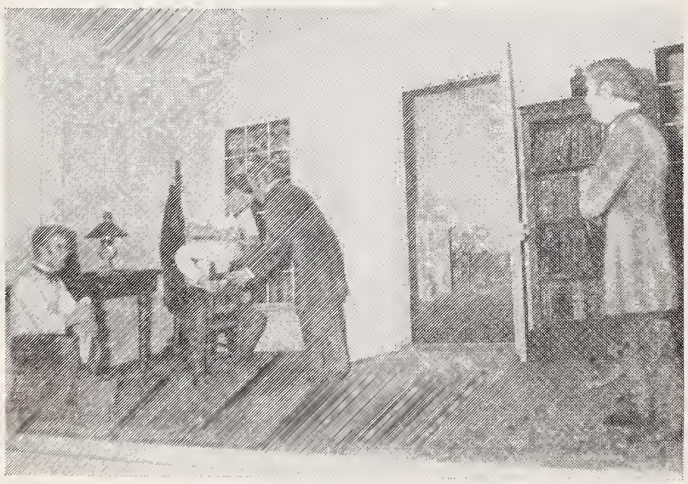
In 1846 Long learned that a William T. G. Morton had demonstrated the use of ether in surgery at Massachusetts General Hospital. On October 16, 1846, Morton, a dentist, administered "letheon" as an anesthetic to a patient while a respected surgeon, John Collins Warren, performed the operation.

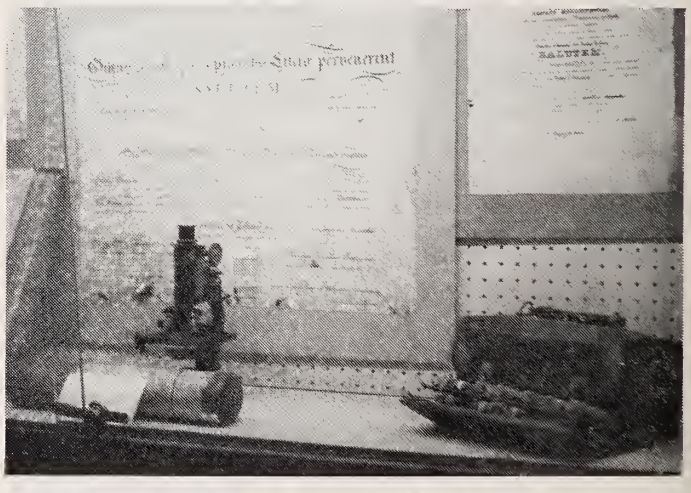
The source for this news was the *Medical Examiner* in December, 1846, which included an editorial quoting a paper by Dr. H. J. Bigelow printed originally in the *Boston Journal.* Long immediately began to write the editor of the *Medical Examiner* to report his use of ether some four years earlier, but a call from a patient interrupted him. Then he waited for the January issue, reading when it arrived several articles on experiments with ether. As the controversy erupted between those claiming to have discovered ether in surgery, Long decided to wait with his announcement. He wanted to know who else had used ether and on what dates.

Long Speaks Up

His first published account of his own use of ether came in December, 1849, in an article printed in the *Southern Medical Surgical Journal.* He wrote, "As no account has been published (so far as I have been able to ascertain) of the inhalation of ether being used to prevent pain in surgical operations as early as March, 1842, my friends think I would be doing myself injustice, not to notify my brethren of the medical profession of my priority of the use of ether by inhalation in surgical practice."

The situation in which he first used ether was described: "At length I mentioned to him (Venable) the fact of my receiving bruises while under the influence of the vapour of ether, without suffering, and as I knew him to be fond of, and accustomed to inhale ether, I suggested to him the probability that the operations might be performed without pain, and proposed operating upon him while under its influence. He consented to have one tumour removed, and the operation was performed the same evening.





At the Crawford Long Museum in Jefferson, a diorama (L) recreates the scene in 1842 when ether was first used by Dr. Long in surgery as he removed a sebaceous cyst from the neck of James Venable. Exhibit cases at the museum (R) offer views of an old microscope and doctor's bag, plus degrees received by Long. Other features of the museum are copies of the commemorative stamp to Long in 1940, formulas for perfumes from his pharmacy, Long family heirlooms, and a detailed history of the development of anesthesia and various devices used to combat pain.

The ether was given to Mr. Venable on a towel, and when fully under its influence I extirpated the tumour. It was encysted and about half an inch in diameter. The patient continued to inhale ether during the time of the operation; and when informed it was over, seemed incredulous, until the tumour was shown to him. He gave no evidence of suffering during the operation; and assured me, after it was over, that he did not experience the slightest degree of pain from its performance."

This account was followed by testimony by Venable and witnesses, plus the testimony of other patients on which ether was used over the next four years.

An abridged version of this paper was read before the Medical Association of Georgia in 1852, with Long saying in conclusion: "I know that I deferred the publication too long to receive any honor from the priority of the discovery, but have by the persuasion of friends presented by claims before the profession. I prefer that its correctness be fully investigated before the medical society."

MAG adopted the following resolution: "Resolved, That this society is of the opinion that Dr. Crawford W. Long was the first person who used Sulphuric Ether as an anesthetic in operations, and as an act of justice to him individually and to the honor of the profession of our own State, we most earnestly recommend him to present at once his claims to priority in the use of this most important agent in the consideration of the American Medical Association at its next meeting."

The AMA did nothing, saying it could not take action in such matters, but in 1870 adopted a resolution declaring Horace Wells to be the discoverer of anesthesia. A motion to reaffirm this resolution two years later was lain on the table.

Controversy Rages

Several persons became involved in the drama of determining credit for the first use of ether as an anesthetic.

Horace Wells was a Hartford, Connecticut dentist who is regarded to be the first to use nitrous oxide gas in the extraction of teeth in 1844. He died in 1848, so did not play a major role in the controversy. In 1864 the American Dental Association passed a resolution declaring Wells to be the discoverer of anesthesia.

William Thomas Green Morton was a Boston dentist. His collaborator, and later adversary, was Charles Thomas Jackson, a physician and chemist from Boston. Jackson is believed to have suggested to Morton the use of ether, and that he disguise it with aromatic substances and call it "letheon." Morton successfully removed a tooth from a patient under anesthesia in September, 1846, and asked to demonstrate it for the staff at Massachusetts General Hospital in surgery performed by Dr. Warren.

Soon after the demonstration, Morton, Jackson and Horace Wells claimed to be the discoverers of anesthesia, with Morton and Jackson agreeing to become "co-discoverers." Jackson, meanwhile, secretly wrote the French Academy of Sciences, which knew his work in chemistry and geology, announcing himself alone to be the discoverer. This highly displeased Morton.

The dispute even reached Congress in 1847 as a $100,000 prize was to be awarded to the discoverer. The prize later was raised to $200,000, but in the end no one received it. In 1854, Senator W. C. Dawson of Georgia entered the name of Crawford Long as the discoverer adding to the confusion, and the debate raged on until the Civil War diverted the attention of everyone.

Jackson was born in Plymouth, Massachusetts, a physician who studied at Harvard. His primary interest was not medicine, but geology, and he completed many important surveys. Jackson developed a reputation for trying to confiscate the accomplishments and discoveries of others. He claimed to have provided the inspiration for Samuel F. B. Morse's telegraph, later saying he was the sole inventor. He also tried to "appropriate" Alexis St. Martin, the patient of Dr. William Baumont whose stomach fistula permitted a unique study on the physiology of the stomach.

In his book, *The First Anesthetic,* Dr. Boland explores in detail the possibility that Jackson heard of Long's accomplishment perhaps as early as the same year the surgery on Venable was performed, and determined to make that discovery his own. Boland's examination includes the fact that Jackson frequently came to nearby Dahlonega in the early 1850's where gold was being mined, and easily could have been there a decade earlier as the mining began around 1829. The stage to Dahlonega traveled from Athens, through Jefferson and Gainesville.

Long Moves to Atlanta, Athens

The controversy raged on. In 1850, Long and his family moved to Atlanta with a home on Broad and Luckie streets. Once there, he felt the budding new city was not the best place for his children, so the family moved to Athens a year later. Long and his wife, Caroline, had 12 children, seven of which lived to maturity.

In Athens, Long and his brother, Dr. H. R. J. Long took over a drug store at 247 East Broad Street. Pharmacy was a particular interest to Long. An early advertisement said the store carried toilet and shaving soaps, cosmetics, pomades, and extracts for the handkerchief . . . and a good supply of medicine.

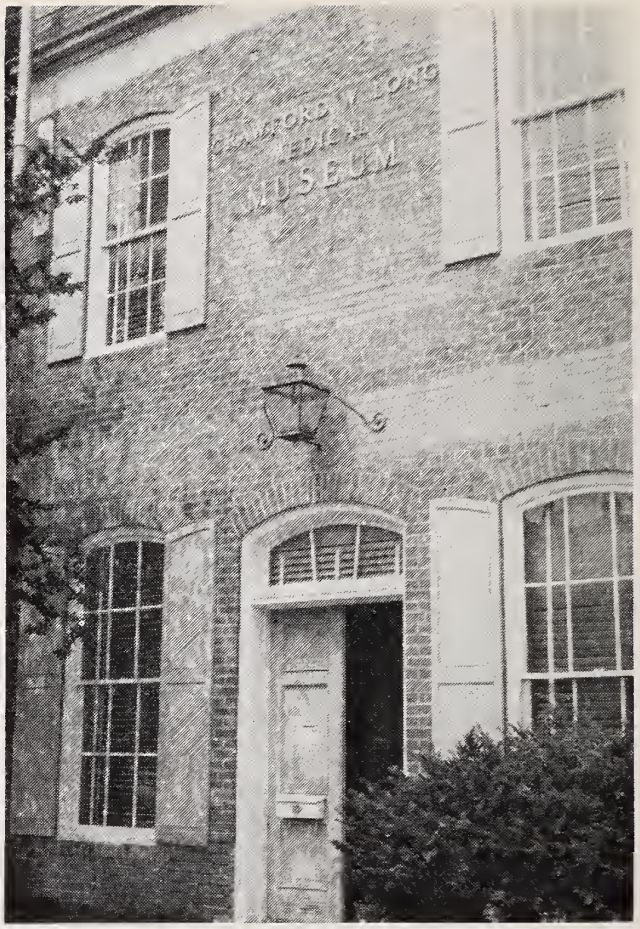
A decade later the Civil War began, and Long served as a physician in Athens for the families of soldiers and for the wounded sent home to recuperate. He enlisted from Clarke County as a private, but there is no record of his being called to active duty. At the time, 1864, he was 49 years old. At the end of the war, Surgeon General J. S. Billins of the U.S. Army appointed Long as a surgeon in Athens to care for both armies until civil government was restored.

Once in 1864, when federal troops threatened to overrun the area, Long instructed his daughter to bury a glass jar containing two gold watches and a roll of papers, which he explained were proofs of his discovery. When the danger passed a day later, the daughter unearthed the jar.

The losses Long suffered in the war were overcome as he had a busy practice and inherited some property. He is believed to have continued the use of ether throughout his nearly 40 years as a physician. When he died June 16, 1878 at the age of 62, he was attending the wife of Congressman H. H. Carlton who was about to deliver a child. The cause of his death was a cerebral hemorrhage. Long was buried in Athens.

Honors Come to Long

In 1878, Alexander Stephens paid tribute to Long before the alumni of the University of Georgia, and suggested that the audience recommend that the State Legislature petition Congress to accept statues of Long and General James Oglethorpe to be placed in the House of Representatives in Washington. Eventually the Legislature selected Dr. Long and Stephens himself for the honor, and the statue finally was placed on March 30, 1926. A replica stands on the Madison County Courthouse lawn in Danielsville. In 1940, Dr. Long was honored with a commemorative postage stamp. Doctors Day, begun by the Barrow County Auxiliary, now is celebrated nationwide on March 30. Time has shown his case to be the strongest and his discovery to be invaluable. ■



The museum to Crawford Long stands off the square in Jefferson. Dedicated in 1957, this building was constructed on the foundation of the original office where Long performed his famous surgery using ether. Today visitors come from every state to the museum filled with memorabilia from Long's life and career.

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2. Young, James Harvey: Crawford W. Long, M.D., a Georgia innovator; *Bull, N.Y. Acad. Med.;* 50:421-437, 1974.

ASK MEDICARE . . .

Q. "How should we handle claims for deceased Medicare beneficiaries?"

A: "The carrier can process an unpaid bill only if the provider accepts assignment. A paid bill requires a cancelled check, or a receipt to establish identity of the person who paid the bill, and must be accompanied by a completed SSA form 1660 (available at the local SSA office). If an administrator or executor has been appointed a copy of the court papers must be sent to the carrier."

Q: "Is it preferable to submit single claims or wait until we have a sizeable number?"

A: "Prudential suggests that you send in a number of claims at one time, and eliminate attachments, extra copies of the 1490 and carbon paper. They add to the weight of your mailing and may require additional postage. Frequently all information can be entered on the face of the Request for Payment."

A supply of large pre-addressed envelopes is available for your convenience at Prudential's Medicare office. Each envelope will hold approximately 75 single-sheet 1490's. Utilization of this means of claims transmittal is one sure way to reduce your office expenses.



Two views of the house which local legend describes as the birthplace of Crawford Long. Research efforts have traced ownership of the home, now up for sale, back at least as far as Long's father, a founder of the Madison County seat, Danielsville.

Crawford Williamson Long: His Birthplace

ONE BLOCK OFF the courthouse square in the northeast Georgia town of Danielsville on a high hill sits the home which legend names as the birthplace of Crawford W. Long. No historical marker identifies the structure. Only a "no trespassing" sign give a clue that the dirt road cutting into trees off the main highway might lead to something.

The Georgia Historical Commission in 1955 did erect a marker at the courthouse which points out the Long birthplace as being one block away.

For six years the two story home has sat vacant while its present owners wait for a buyer who would be interested in restoring the structure, not tearing it down and clearing the 41 acres for some other purpose.

Mrs. Leslie Oglesby, who moved to the area from Atlanta six years ago, learned of the home through her friendship with the current owners and is trying to save it. She has spent the last two years researching Long family papers and the archives of surrounding counties, coming to the conclusion that it is the birthplace. Her efforts have been complicated by the fact that the property evidently was first sold before the current county, Madison, was formed in 1811.

Ownership Traced

Mrs. Oglesby located the early plat of the town and has traced ownership of the property on which this house stands back to Long's father. Fortunately the land has changed hands infrequently. James Long willed it to his wife, Elizabeth Ware Long, upon his death in 1853. She died in 1856, and Crawford and his brother, H. R. J. Long sold the property in April, 1874 to their brother-in-law, Samuel P. Thurmond for $1,800. Eleven years later the house went to Stephen C. O'Kelley, who kept it until 1942, when it was sold to H. P. Sorrow. The Sorrow family still owns the house and 41.07 acres, for which they want $46,000. Offers from developers merely interested in the property but not in restoring the home have been turned down, Mrs. Oglesby says, but the family is getting anxious to sell.

Believing that this is the Long birthplace, Mrs. Oglesby hopes to get the structure "authenticated" and placed on the National Register of Historic Places. Beside the obvious recognition this would bring to the home, the honor carries with it a possible financial advantage in that matching funds for restoration of the site might become available. Mrs. Oglesby brought the home to the attention of the Northeast Georgia Area Planning and Development Commission two years ago. She has received the help of their National and Historic Resources Advisory Committee and the Historical Preservation Section of the Georgia Department of National Resources.

In order to be designated an historic site, a location will be evaluated according to the following criteria: its significance in American history; its association with events that have made a significant contribution to broad patterns of history; its association

with the lives of persons significant in history; its embodiment of characteristics of a type, period or method of construction; its ability to yield information important to prehistory or history.

The home was described by Long's daughter, Mrs. Frances Long Taylor in her 1928 biography of her father, and she says Long was born in the house to which his mother was carried as a bride. On a recent trip to the Crawford W. Long Museum in Jefferson Mrs. Oglesby found a paper by Long's student in pharmacy, Joseph Jacobs. He wrote that Long's grandfather, Samuel, built the house in Danielsville after moving there from Carlisle, Pennsylvania in 1792. Again, county records in Madison do not date back that far so further checking is necessary. Madison was created from sections of surrounding counties, and some of the records of these counties have been destroyed by fire over the years.

Frances Long Taylor says the home had eight rooms and fine oak paneling. A drawing of the Long birthplace is held in the collection of Dr. Hugh H. Young. Both *could* be the home Mrs. Oglesby is investigating, allowing for the additions made through the years to the original structure, such as a porch and extra rooms. The original home was built with two rooms over two rooms.

John Waters, president of the Athens-Clarke Heritage Foundation, recently examined the home and felt it was built in the early 1800's, or perhaps the 1790's. He discovered that the center hall was not original, but created from one of the original rooms. Part of the evidence indicating early 19th century construction of the house is the use of the segmented arch in the fireplace openings. The grounds now also hold a covered well, carriage house, barn and a meat curing house.

As the birthplace of this famous Georgian, and for its architectural detail, this home should be saved.



Mrs. Leslie Oglesby examines the brickwork of the Long birthplace. She is spearheading efforts to save the home, and hopes that it will be restored by the next owner. Applications have been submitted to have the site placed on the National List of Historical Places.

NEW COLLEGE TO HOLD ANNUAL CONVENTION FOR FMGS

The newly organized American College of International Physicians, Inc., composed of licensed practicing physicians who are graduates of medical schools outside of the United States, will hold its first Annual Convention, Scientific Session, and Convocation of Fellows, in Chicago, on the weekend of October 16-17, 1976.

The new College was recently incorporated as a nonprofit, tax-exempt corporation, and is devoted to the international physician's education and continuing advancement of his skills in medicine. The College will provide a forum for highly qualified international physicians and surgeons to advance the highest standards of medical education, practice, research and ethics.

Fellowship in the College is open to all physicians who received their medical education in schools outside the United States, and who have been licensed to practice medicine for three years or more. Associate and affiliate Fellowship is open to all who do not meet the above requirements.

College activities will center about the Annual Scientific Meeting and Annual Convocation of Fellows which will be held in different cities throughout the United States and will be highlighted by the presentation of the Distinguished Fellowship Award, which will be made each year, to an international physician who has distinguished himself in the field of medicine and who best exemplifies the high standards of the College.

Further information and requests for application forms and reservation forms for the meeting can be obtained from the College Offices, at Suite 12, 3030 Lake Avenue, Fort Wayne, Indiana 46805 in care of Antonio B. Donesa, M.D., President.

The catastrophe began when two infected crewmen were brought ashore; it was compounded by the ignorance and fear of local officials.

The St. Marys Yellow Fever Epidemic of 1808: Georgia's First Confrontation

GERALD L. CATES, Ph.D., *Athens**

MANY TERRIFYING EPIDEMIC diseases have plagued mankind throughout his brief history on this planet. For Georgians living in the eighteenth century the chief danger undoubtedly lay with smallpox; but by the beginning of the nineteenth century, a new and even more terrifying specter appeared—yellow fever.

Smallpox still represented a real danger, but at least it was a rational one. It usually traveled in a clearly distinguishable line directly from one victim to another. There was no cure, but isolation of the sick could successfully contain an outbreak while inoculation, and later vaccination, provided permanent immunity. Consequently, most Georgians saw smallpox as a terrible but comprehensible adversary. This was not true of yellow fever, or as it was commonly known, "the black vomit." Its seeming irrationality magnified normal feelings of fear and panic and made the disease especially terrifying. However, yellow fever did have one thing in common with smallpox; both diseases exemplified the relationship between disease and social structure. This relationship was especially revealing in the case of yellow fever, because it was not native to Georgia in 1733 nor was it considered a problem during the colonial period. The natural environment of eighteenth-century Georgia would not sustain it, and it became a threat only as a result of man's efforts to alter that environment to fit his needs. Without realizing it, he also created a habitat that not only sustained the carriers of yellow fever but encouraged their expansion.

Classic yellow fever is produced by a virus transmitted by a domestic mosquito, the *Aedes aegypti*. The disease itself is an acute form of communicable jaundice, resulting from liver necrosis. The symptoms are fever; pain; petechiae; and granular, black vomit made up of partially digested blood produced by internal hemorrhaging. Because the black vomit and even the more common symptom of jaundice did not always appear, eighteenth-century physicians failed to distinguish among various forms of the disease and often simply identified cases without either black vomit or jaundice as simple remittent or bilious fever. Consequently, a great deal of confusion existed as to the true nature of the disease. This confusion is still reflected in the writings of contemporary medical historians when they attempt to distinguish between actual cases of yellow fever and other febrile diseases common to the era.[1]

Early History of Disease

Most authorities believe yellow fever originated in either West Africa or India. Certainly by the early seventeenth century it was endemic in most West African ports from where it was brought by pirates and slaves to the Americas. There were several pre-Colombian reports of yellow fever in South America, most notably in 1454 on the Mexican Plateau and in the Yucatan between 1477 and 1497, but no verifiable outbreaks occurred until the mid-seventeenth century. It was apparently carried to the Barbados Islands in 1647 and was first clearly described in 1694 by a Spanish physician, Ferrevra de Roas. Skipping rapidly from port to port, it first appeared in British America in 1699 when it erupted in Philadelphia and Charleston. Similar epidemics struck Philadelphia again in 1703, 1728, 1732, and 1740 and Charleston in 1741, 1748, and 1762. Other ports were less seriously affected. For some unknown reason, between the 1740s and the late 1780s yellow fever nearly disappeared from British America.

However, beginning again in 1790, it struck the Atlantic seaboard with a rapidity and destructiveness unknown in the past. In 1794, New York was hit. In 1795, it was New York, Baltimore, and Norfolk; and in 1796, the fever again returned to New York. Philadelphia had epidemics in 1797, 1799, 1802, and 1803; Charleston was attacked in 1792, 1794, 1795,

* Ex-officio member of the Ad Hoc Committee on the Bicentennial Celebration. Dr. Cates's address is 480 Pine Needle Road, Athens, Ga. 30601.

1799, and 1800.[1–4] The whole Atlantic seaboard seemed under seige.

Because yellow fever's early symptoms resemble those of malaria and because it usually appeared in regions where malaria was endemic, it was often mistakenly associated with the swamp and the miasma that supposedly originated there. Actually, the *Aedes aegypti* prefers an urban environment where wooden buildings provide it with shelter and a favorable breeding habitat. Furthermore, the *Aedes aegypti* has a limited range. Once infected by a human carrier, it rarely travels more than a few hundred yards from the point of infection. Thus, it threatens only compact communities. Indeed, certain very specific conditions are required before an epidemic is possible. There must be an active *Aedes aegypti* population, three weeks of hot weather following the infection of a mosquito by a carrier, and a number of infected carriers in a compact, susceptible community.[1] The deep forests and swamps, rural population, and small, scattered settlements of eighteenth-century Georgia simply did not provide a viable habitat for the mosquito. However, once urban centers started to expand in the late eighteenth century, the *Aedes aegypti* a marginal species in virgin forests, began to find areas favorable to its growth and to expand rapidly within these isolated, urban pockets. By the early nineteenth century, all of the larger towns of Georgia—Savannah, Augusta, and St. Marys—probably harbored thriving colonies of *Aedes aegypti*. As the numbers of carrier mosquitoes and susceptible victims increased within these communities, the epidemic potential increased proportionately. Naturally, seacoast towns were more exposed than inland communities, because they had not only the largest and most concentrated populations but also the most frequent contact with travelers from West Africa and the Caribbean, where yellow fever was endemic.

In spite of Georgia's growing contacts with the Caribbean and West Africa in the late eighteenth century, it was the early nineteenth century before yellow fever first appeared in the state. Verified cases were reported in 1801 and again in 1807 and 1808, and Georgia suffered its first significant outbreak late in 1808 when yellow fever erupted in St. Marys, near the Georgia-Florida border.[5]

The Stage Is Set

Before 1808, St. Marys, a coastal village of 350 whites and 150 blacks, was not considered unusually prone to disease. Of course, it had the normal medical problems of the region; malaria and typhoid could be especially troublesome, but for the first half of 1808, the community seemed generally free of disease. However, in late August and early September heavy rains "filled all the low ground, and the water lay on the surface of the ground for some time. . . ."[7] The town wells soon filled and some became foul; yet, no one seemed to notice any increased illness as a result. Then, on September 5, a coastal packet from Savannah arrived with two seriously ill crewmen, who were allowed ashore before a health official had examined either them or their vessel. This was true despite, or perhaps because of, the fact that the cargo consisting of corn and other provisions, proved so foul that local officials later found it "distressing to go on board. . . ."[7] One ailing seaman died a few hours after being brought ashore; his shipmate followed him several days later. Shortly after the second death, two more crewmen became ill and died and the ship's passengers also began to show early symptoms of yellow fever. Nevertheless, local officials reported that there was no need for alarm.[7]

Later, many residents of the town would blame these same officials for the introduction and rapid expansion of the epidemic. They claimed there had been negligence in enforcement of certain statutes, particularly quarantine and anti-smuggling laws. Large quantities of rotten provisions had been allowed to accumulate in warehouses habitually used by local smugglers for storage. In conjunction with heavy rains that preceded the outbreak, these stored provisions did probably form an ideal breeding ground for *Aedes aegypti,* and smugglers, with numerous contacts in Florida and the Carribean, were apparently frequent carriers of the yellow fever virus. However, the people of St. Marys normally profited from the smuggling and prior to the epidemic seemed quite willing for it to continue. Also, it should not be overlooked that, while smugglers may have contributed to some degree, the town itself—susceptable people grouped in a relatively small area—really set the stage for the outbreak.[7]

The first community resident to die was James M. Lindsay, a nurse for one of the sailors from the stricken ship. Lindsay's death occurred nine days after the infected ship's arrival. One day later Sip, a free black man who also attended the seaman, died. Shortly afterwards, the sickness, which by this time was unmistakably yellow fever, began to spread rapidly through the town. Those stricken were first seized with severe headaches and low back pains followed usually by chills similar to those experienced during a malaria attack and by "great oppression in the chest, pains in the legs, high fever, and delirium."[7] Five to eight hours after the first

symptoms appeared, the patient was often completely incapacitated. Death came quickly; several apparently healthy individuals died 24 to 48 hours after the first attack. In most cases, black vomit or bleeding at the mouth and nose took place just before the end. If the fever's violent character failed to panic the town, its awesome effect on the corpse surely did. Once breathing ceased, "the body . . . assumed a yellow, then a purple, and afterwards a black colour, and was immediately in a state of putrification. . . ."[7]

In spite of numerous obvious warnings of disaster, the Town Council reacted slowly and reluctantly. A Committee of Health was not appointed until September 28, too late to be effective. Residents were not advised regarding precautions they might take, nor had the Council tried to establish a hospital or clinic for the poor. Finally, on September 29, the Council began to act, but by this time the epidemic was already out of control. A survey on that day revealed 55 cases of yellow fever, 31 whites and 24 blacks.[7]

Panic Evacuation

Led by a few local physicians, St. Marys began a belated effort to mobilize her medical defenses. Soon after the Committee of Health issued its report on the extent of the epidemic, it established a temporary hospital and provided nurses, medication, and nourishment for the poor. It supplied coffins and saw that the dead were quickly buried and that their clothing and bedding were burned. Fortunately, few had waited for official guidance, and by late September most of St. Marys' 350 white residents had put as much distance between themselves and the fever as possible. By October 2, the town's population was reduced to only 100, and most of these were either sick or black. At one point, St. Marys' entire white population consisted of eight persons, probably physicians. Although none of the fleeing sick survived, the mass white evacuation undoubtedly reduced mortality.[7] Because yellow fever is not spread by contact, evacuation represented no serious health hazard to surrounding rural areas.

In spite of its local character, the epidemic proved highly destructive. Out of a population of 350 whites, 87 contracted the disease and 42 died. Forty-five of the town's 150 blacks caught the fever, but only three died. Therefore, while only 25 percent of the whites became ill, with a mortality rate of 25 percent, over 30 percent of the blacks caught the fever, yet their mortality rate was only 6 percent.[7] Fewer whites contracted yellow fever because most of them fled beyond the range of the disease leaving only the sick, the blacks, and a few physicians in the town. The blacks, many of them natives of West Africa and the Caribbean, possessed some natural immunity which explains their remarkably low mortality rate.

Opinions on Treatment

There were two local schools of thought on the treatment of yellow fever. The largest and most popular one was led by Dr. Daniel Turner, a newly arrived medical graduate from Rhode Island. Initially, Turner felt preventive measures might ward off the fever. He advised abstinence from meat and hard liquor and consumption of copious amounts of lemonade. However, once the disease struck, his main concern seemed to be the constipation that usually followed. Because opening the bowels was his first priority, Turner's prescriptions stressed heavy doses of calomel, jalop, and occasionally tartar emetic and glaubis salts. In at least one case, over 100 grams of calomel were administered within a three-day period. If cathartics failed, Turner resorted to clysters, warm baths, blisters applied to the stomach, massage with laudanum, and brandy taken internally. Although bleeding was the treatment urged by Benjamin Rush, the nation's leading authority on yellow fever, it was not widely used. Turner reportedly bled himself, but only one other phlebotomy was recorded. In both instances, death occurred shortly after the operation.[7]

Turner's only medical rivals were a few physicians who prescribed free use of mercurial ointment externally and mercury internally. However, this group never achieved Turner's popular support largely because of the opposition of a small colony of French emigres then living in St. Marys. As a group they opposed the mercury treatment and when none of the emigres contracted the fever, the community at large tended to regard their continued good health as proof of mercury's ineffectiveness.[7] Actually, their invulnerability may have stemmed from their recent emigration from Santo Domingo where yellow fever was endemic. They probably had either survived the disease and were immune or possessed some natural resistance resulting from constant exposure.

Once the epidemic passed, it was obvious to most of the town's residents that it had been a catastrophe made worse by the negligence or cowardice of local officials. Only the community's physicians emerged from the ordeal with their reputations enhanced. Working to the point of exhaustion, both private physicians and the Committee of Health performed admirably. However, their courage and dedication had its price; among the 45 Georgians who died were Dr. Ebenezer Stowell, Dr. L. Hitchcock, and Dr. Daniel Turner.[7]

The St. Marys epidemic was not a major one when

compared to the earlier experiences of New York, Philadelphia, or Charleston. The mortality, while disastrous for the village itself, could not be compared with the hundreds who died in some of the large towns along the east coast or in the Caribbean during this period. Nevertheless, for Georgia the St. Marys epidemic was ominous; for to the north in Savannah and Augusta similar conditions existed on a much larger scale. In either of these two cities the mortality potential was far greater than at St. Marys. Just how large, the state would soon learn. ■

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Come Fly With Me

WILLIAM J. MORTON, M.D., *Chamblee**

BECAUSE OF THE BUSY schedule in our daily routine and in constantly meeting the high standards of our profession, there should be and in fact must be a pursuit of other pleasures as a vent to relieve pressures. We all belong to organizations mostly involved in our sphere of medicine, but I would like to share with you an organization, international in scope, varied in membership, and combining two of our finest inspirations—medicine and aviation. For those of you who have not experienced the joy of piloting your own plane nor been a passenger in a small airplane, is to miss out on one of life's most exhilarating and enjoyable moments. To experience the thrill of soaring above the earth, to behold not only man's contribution, but also nature's bounty and also to enlarge one's knowledge learning aerodynamics, navigation, and radio-communication is another means of growth and widening of experience. Rather than proselytize the reader to flying, I would like to tell you about the Flying Physicians Association.

This organization is composed not only of physician-pilots, but also any physician who may have only a casual interest in aviation. Open to medical students, interns and residents as well, the organization is a forum for expanding ones medical and aviation knowledge. The aim of the Flying Physicians Association is to promote general aviation safety, both through example and education. We also strive to advance pilot proficiency and physician knowledge, to encourage aviation interest in our youths, and to promote aviation awareness within the ranks of the medical profession. Besides having members in every state, our members are also located in Canada, Africa, Australia, England, Israel, Puerto Rico, Colombia, South America, West Germany, and the West Indies.

Founded in 1955, with its first regular meeting held in conjunction with the A.M.A., the membership has increased to over 2,400. Besides its own state, regional, and national meetings, the Flying Physicians Association also meets at the same time as the American College of Surgeons, the American Association of General Practitioners, Southern Medical Association, the American Medical Association, and the Aerospace Medical Association. Obviously the high point of the organization is the National Flying Physicians annual meeting held in the summer of each year. Last year we met for one week at Lake Geneva, Wisconsin; this year we assemble at Toronto, Canada (July 25-30) and next year we meet at Sun Valley, Idaho. The National meeting not only has topics of medical interest and special aviation speakers, but last summer we were shown a film made by the physician who covered the joint U.S.-Soviet space shot for NASA. We were the third organization to see this movie after President Ford and the National Press Association. There are also aviation manufacturers demonstrating their products from navigation and communication equipment to oxygen systems as well as different type of aircraft. Representatives of the Federal Aviation Administration as well as the major commercial airlines usually speak on some pertinent subject. Of course, there is also the usual complement of medical topics and since it is not an organization comprised of one particular sphere of medicine, the topics vary from orthopedics to general practice, survival medicine and ophthalmology. The meetings actually expose the specialist to what's going on in the other aspects of medicine.

Of course, the social aspects are not to be denied. You'll meet interesting people. Swapping scary airplane tales (hangar flying) take precedent over everyone's favorite horror show in his practice. I am always amazed as to how many physicians not only are accomplished pilots, but also how involved we all get in flying.

The sites for the meetings are carefully chosen—not only to encourage members to attend, but with members flying to the locations, they're usually in more unusual places. At our last regional meeting held at Jekyll Island this past March with 60 registrants, there were over 45 airplanes present. Of course, not everyone owns his own plane and many members are not pilots, but most members do fly in private planes to the meetings.

While the Flying Physicians Association is primarily an educational organization, its members do engage in a variety of other activities. Perhaps most

* President, Dixie Region Flying Physicians Association. Dr. Morton is a urologist in practice at the Embry Hills Medical Center, 3646-F Chamblee-Tucker Road, Chamblee, Ga. 30341. Dr. Morton is an instrument rated pilot.



Three of Dr. Morton's daughters, (L-R) Wendi, Heidi and Pam, enjoy a trip to Hilton Head Island aboard their father's Cherokee Six.

notable among these are the Association's emergency mobilization plan. The plan is designed to provide outside medical aid and assistance in the event of a major disaster. In such an event the members—at their own expense—are formally organized and prepared to provide the medical supplies and personnel that would be urgently needed and in all likelihood not available at the disaster site. This is a task uniquely suited to us as physicians. We have readily accessible to us such supplies and personnel, and our aircraft are capable of landing in areas completely unsuitable for commercial and/or military use. Each year the various state chapters stage mock disaster flights. Often these are held in cooperation with other agencies with similar programs. The FPA disaster program in no way conflicts with those of the Civil Air Patrol, or other organized groups with similar plans.

In addition to the National Convention and other regional and state meetings, the Association also sponsors one or two group flights. The first of these was held when a group of members toured Alaska in 49 airplanes. A tour of Hawaii was conducted subsequent to that. There have also been many group flights to Mexico, maritime provinces of Canada, and one each to the Caribbean, Guatemala, and Colombia, South America.

The Association regularly distributes without charge two publications to the membership. "The Flying Physician" is a magazine issued quarterly and devoted mainly to papers and articles concerning flight safety and medical reports related to aviation. It also carries news of the activities of various state chapters. "The Bulletin" is a monthly newsletter containing information of a much more immediate nature for the general membership. By the way not only are the annual dues extremely low, registration charges at the meetings are always minimal!

Of the several committees of the Association, none is more important than the Safety Committee. Ever since the FPA was founded, members of this committee have been extremely active in a variety of ways, producing audiovisual aids, stressing the importance of adequate and continued instrument training by both medical and nonmedical pilots, and co-operating with state and local government agencies.

Members of the Flying Physicians Association do not want publicity. Too often the public is given a distorted picture of the physician flying his own airplane. What the FPA wants most of all is for people —not only other physicians but also the public at large—to realize that being a member of the Flying Physicians is a privilege as well as a tremendous responsibility. The organization is a complex entity made up of fun plus learning painstaking care in piloting a plane. All this plus research and an incessant interest in the latest in aerospace medicine, flight techniques and scientific progress make for a fascinating group.

But is this a brief summary of what the Flying Physicians Association is about. I encourage curiosity and I invite your participation. As we say here in Dixie, "Ya'll come, heah!" ■

Commitment and Involvement or The Price of Liberty Is Always High

WHAT A SOURCE OF PRIDE it is to look back 200 years in our history and to contemplate the signing of our Declaration of Independence; to realize that this bold experiment unique in world history has sustained us through too many crises to enumerate and that today we remain the most free and productive nation on the face of the earth. Of added satisfaction to us is the documented evidence that physicians were "in" on the action from the very beginning. Their role was hardly a passive one. Indeed, the first physician's signature on the document is that of Josiah Bartlett, M.D., who represented the most "Easterly Province." He was a respected country physician who served as a colonel in the militia. He also served as a Justice of Peace and was elected the first Governor of the State of New Hampshire. We are most familiar with the activities of Lyman Hall, M.D., who was one of the signers from the Colony of Georgia. He was a native of Connecticut, who graduated from Yale College and migrated to Georgia to practice medicine and operate a plantation. In 1783 he was elected Governor of Georgia and was instrumental in establishing the University of Georgia, the first state owned university in the United States (preceding the land-grant colleges by almost 100 years).

Dr. Benjamin Rush, a delegate from Pennsylvania, was considered the outstanding American scientist and medical man of his time. He was only 30 years old at the time he signed the historic document.

Paul Revere's Companion

On the night of April 18, 1775, Paul Revere, Dr. Samuel Prescott (a Boston physician), a Mr. Dawes and others made the night ride to alert the minutemen. Revere was captured at Lexington but Dr. Prescott escaped and reached Concord. So successful was Dr. Prescott that the British were stopped at Concord and forced to withdraw with severe losses to Boston under protection of a relief column sent to the rescue.

At the Battle of Bunker Hill, 31 physicians and surgeons were in the American fighting ranks. Eleven of their number were killed in this bloody engagement in 1775.

The names of these men will remain forever a part of the record of the American Revolution. However, there were many other physicians whose military and political activities were mentioned in the journals of the Provincial Congress and it is from these old historical records alone that we learn the extent of the service rendered by the medical profession to the new nation.

These men were willing to lay their lives and their reputations on the line in their pursuit of freedom for their colonies and their families. They under-

stood what total commitment meant, and to them the alternatives were unthinkable.

This is not to deny that there must have been a considerable number of physicians who were loyal Tories and who felt that their secure, buttondown, play it safe, don't rock the boat philosophy was the rational thing to do. After all, why should they risk their lives and their future when they enjoyed so favorable a position in their own little myopic worlds. Thank God for the future of America and American medicine these men did not prevail. They were quietly relegated to the ash heap of history.

Threats We Face Today

Today we face new threats which are no less urgent than those of Colonial days. Our threat this time comes insidiously from within our country. The threat, of course, is "creeping federalism," socialism or whatever you choose to name it. Many responsible citizens recognize it for what it is and what it portends for all of us. If we can believe the politicians, the majority of citizens have embraced its concepts and branded it inevitable for us in this country—a sort of "wave of the future."

Built into these concepts is the notion that unlimited medical care is a God given right without regard to the unrealistic economics involved. Because of the economic illiteracy of many physicians and laymen, the relationship of government to medicine has not been recognized as a serious problem. It does not require an economist to recognize that government financed unlimited health care for all would bankrupt our country in short order, with the associated run-away inflation and other problems.

Let us as physicians take heart from the example set for us by our colleagues of Colonial times. Rather than sitting quietly in our comfortable little worlds (which are crumbling around us), let us become involved more directly in government and political affairs in an effort to lend stability to a rapidly changing situation. With the inspiring example set by our Colonial forebears, can we afford to do less?

E. W.

GAFP MEETING TO INCLUDE SPEAKERS' WORKSHOP

"Two Hundred Years of Medicine" will be the 1976 theme of the 28th Annual Session of the Georgia Academy of Family Physicians. The meeting will be held November 10-14 at the Terrace Garden Inn in Atlanta. Over 200 physicians are expected to attend.

The program for the meeting will include a list of renowned medical speakers. An innovative feature of this year's program will be a speakers' workshop which will follow the general session, and will be designed for doctors who frequently are called upon to speak to civic groups. Expert instructions will be provided by staff members of the American Academy.

In addition, the program will include the presentation of the Distinguished Service Award and Certificates of Appreciation. The incoming president of the Georgia Academy will be installed. An officer of the American Academy will attend as will American Academy personnel.

Pre-registration materials and the complete program will be mailed on September 1.

president's letter

Bicentennial Time



Happy Birthday, America!

Celebration of July 4, 1976, is finished. Don't believe any of us have set up a task force to plan the tricentennial celebration.

Despite our in-house problems, few of us Americans who have been privileged to travel to other countries want to settle elsewhere.

Rereading the Constitution and Bill of Rights is sure a lot easier than perusing the rules and regulations for Medicaid from HEW.

Good luck to each of you as you continue your individual tasks in the delivery of medical care.

We are fortunate to have varied philosophies and talents which motivate the advances in quality of medical care.

At the same time, let us not permit our idiosyncrasies to lead to self-destruction.

Continuing to combine the dedicated efforts as friends in medicine, we should be able to find some degree of happiness in our embarkation on the next hundred years of the USA.

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

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Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

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Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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cancer page
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cancer page

Estradiol Receptor Assay (ERA) In Breast Cancer

ROBERT G. BLAKER, Ph.D., *Van Nuys, California**

SINCE THE PIONEER WORK of Huggins and Bergenstal in 1952[1] showing that hormone deprivation resulted in marked tumor regression in some patients with advanced breast cancer, there has been great interest in endocrine therapy of metastatic breast cancer. Clinical studies have shown that approximately one-third of all patients with metastatic breast cancer will respond to endocrine ablation therapy, while the remaining two-thirds will be non-responsive. It is therefore extremely important for the physician to be able to differentiate between "hormone responsive" and "non-responsive" tumors so that endocrine therapy can be restricted to those cases where there is a good probability of success, while sparing others the trauma of a major operation and considering them instead for alternative therapy at an earlier time than would otherwise be possible.

In 1967 Jensen et al.[2] reported the use of an in vitro assay to measure the estradiol binding capacity of breast cancers. An excellent correlation was found between the ability of the tumor extract to bind estradiol in vitro and the responsiveness of the tumor in vivo to endocrine ablation therapy. These findings were soon confirmed by others,[3–5] and at a recent workshop in Bethesda, Maryland, investigators working under the auspices of the National Cancer Institute presented an extensive and carefully monitored study of the Estradiol Receptor Assay (ERA) in a series of approximately 500 patients with metastatic breast cancer (Table 1). The study revealed that, of 211 women who had endocrine ablation therapy, 55 percent with estradiol positive (ER+) tumors showed objective remission compared to only 8 percent with estradiol negative (ER−) tumors. Similarly, of 170 women who received steroid therapy, 60 percent of those with ER+ tumors showed tumor regression, compared to only 8 percent of those with ER− tumors. The data clearly show the excellent prognostic value of the Estradiol Receptor Assay in predicting the response of particular breast cancers to endocrine therapy.[6]

The ERA Method

The method used in our laboratories involves the extraction of the highly labile receptor from the tumor by pulverization of the tissue at liquid nitrogen temperature. The tissue powder is allowed to thaw at 4°C and the cytoplasmic receptor is carefully separated from lipids and incubated with ^{3}H-labelled estradiol, which interacts with the binding sites of receptor. The excess estradiol is separated from estradiol-receptor-complex by absorption of the free steroid with dextran-coated charcoal. The amount of non-specific binding (e.g., to albumin) is determined by specifically blocking the receptor sites with nafoxidine. The quantity of estradiol

* Bio-Science Laboratories, Van Nuys, California 91405.
Prepared at the request of the Professional Education Committee, Georgia Division of the American Cancer Society.

TABLE 1

NCI STUDY

Therapy	Correlation of Response to Presence of Estradiol Receptor in Tumor Tissue Incidence of Objective Remission* ER+	ER−	ER±
Adrenalectomy	32/66	4/33	3/8
Castration	25/33	4/53	0/2
Hypophysectomy	2/8	0/8	—
TOTAL	59/107 (55%)	8/94 (8%)	3/10 (30%)
Androgen	12/26	2/24	0/1
Estrogen	37/57	5/58	0/2
Glucocorticoid	2/2	—	—
TOTAL	51/85 (60%)	7/82 (8%)	0/3 (0%)
Antiestrogens	8/20	5/27	—
Other	2/3	0/5	—
TOTAL	10/23 (43%)	5/32 (16%)	—

*** Number of patients with remission/number of patients treated. Objective remission is defined as more than a 50 percent decrease in size in at least half of the measurable lesions, with no progression or growth of any lesion.**

receptors in the tissue is estimated as the total binding minus non-specific binding per milligram of protein.

Upon testing a variety of breast cancers it is seen that they can be divided into two groups based upon their relative binding capacity. Benign tumors and some malignant tumors exhibit little binding capacity and are designated ER−. Other malignant tumors have a higher degree of binding capacity and are designated ER+ if their binding capacity is marked, and ER± if their specific binding activity is borderline. Tumors that are ER+ show a good correlation with successful endocrine therapy, while tumors that are ER− have less than 10 percent probability of favorable response.

There is some evidence that the binding capacity of the primary tumor, determined at the time of mastectomy, will predict the responsiveness of metastases to endocrine therapy. The physician is thus able to obtain prior knowledge of the probable hormone responsiveness of the metastatic tumor and can institute appropriate therapy with minimum delay following tumor recurrence.

The conclusions of various studies substantiate the view that the results of the Estradiol Receptor Assay, considered in conjunction with clinical and laboratory data, will be a valuable aid to the physician in choosing the optimum therapy for the patient with breast cancer.

The estradiol receptor is very labile and the specimen must therefore be collected and transported according to rigidly-defined criteria. The laboratory needs at least 1 gram of tumor tissue, which must be trimmed free of surrounding fat and normal breast tissue; in addition, it is imperative that the tumor be placed on Dry Ice within 15 minutes after surgical resection, and shipped as soon as possible in Dry Ice to the laboratory. The specimen must not be fixed with formalin or other preservatives. If any of the foregoing conditions is not met then the results of the test may not be valid. ■

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Prophylaxis of Endocarditis and Rheumatic Fever

RICHARD E. DUBOIS, M.D., *Atlanta**

PROPHYLACTIC THERAPY should be given to patients with congenital, rheumatic or other acquired valvular heart disease. This includes those patients who have had rheumatic fever in the past with a documented episode of carditis even though clinical examination may not reveal valvular heart disease currently. It also includes those patients with a prosthetic value or who are undergoing cardiac valve surgery[1] and, for the present time, patients with the so-called "murmur-click syndrome." Although the risk of endocarditis in this latter group (recently described as 6.3% of a normal adult female population) has probably been overstressed.[2, 3]

The prophylactic antibiotic therapy must be as specific as possible, but must not be initiated too soon prior to the manipulation or surgery. Prompt recolonization of the involved areas could occur prior to the procedure itself if the antibiotic prophylaxis is initiated too early. Such colonization would likely be with resistant strains of bacteria and the prophylaxis would, therefore, become ineffective for prevention of endocarditis at the time of the procedure. Therefore, it has been recommended[4] that prophylaxis be initiated approximately one hour prior to the procedure. For this same reason patients who have been on rheumatic fever prophylaxis with penicillin should use another drug besides penicillin as the agent of choice for endocarditis prophylaxis during dental procedures.

Patients undergoing cardiac surgery should have prophylaxis directed against Staphylococcus aureus, Staphylococcus albus, pneumococcus, and Streptococcus. This can be accomplished with intravenous Nafcillin. Patients allergic to penicillin should receive Vancomycin or a Cephalosporin.

Two Bacteria Groups

A vast majority of episodes of bacterial endocarditis (excluding endocarditis associated with illegal drug abuse) are the result of Streptococcus viridans or Group D Streptococcus. Prophylactic efforts are, therefore, directed toward these two groups of bacteria. When the operative or manipulative procedure involves the mouth, Strep viridans is the most probable pathogen. A satisfactory program for endocarditis prophylaxis during dental procedures would be Penicillin-V 500 mgs. p.o. one hour prior to the procedure and three hours after the procedure and then every six hours for the rest of that day and for the next two full days. In those patients allergic to penicillin or in those patients who have been on chronic penicillin therapy as prophylaxis for rheumatic fever, Erythromycin provides a satis-

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Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

factory alternative. The author prefers Erythromycin Estolate despite the very remote risk of cholestatic hepatitis which has been reported as a rare complication of therapy for greater than 14 days in adults. However, the Erythromycin Ethylsuccinate or Stearate is probably effective if taken on an empty stomach. This, however, is sometimes difficult to tolerate. The author believes that there is no place for plain Erythromycin (Base) in this situation. The dosage for the Estolate and Stearate is 250 mgs. while that for the Ethylsuccinate is 400 mgs.

When the procedure involves the genito-urinary or G.I. tract, especially manipulation of the urethra, prophylaxis for the Enterococcus must be provided (Enterococcus is the more pathogenic species of Group D Streptococcus). This is best accomplished with Ampicillin and Streptomycin. When oral prophylaxis is used Amoxicillin is superior to Ampicillin.[5] Streptomycin, of course, must be given intramuscularly. Amoxicillin is given in 250 mg. doses and should be administered on the same schedule as for Penicillin-V. Streptomycin should be given as one gram intramuscularly one hour prior to the procedure and once daily thereafter for two days. Patients that need to be "N.P.O." during the immediate period prior to a procedure can have Ampicillin administered 250 mgs. intramuscularly as a substitute for the initial dose of Amoxicillin. Erythromycin is not an adequate substitute for Amoxicillin in those patients who are sensitive to the penicillins when prophylaxis is being directed against the Enterococcus. Vancomycin should be used without Streptomycin in these circumstances. It can be given as 500 mgs. intravenously one hour prior to the procedure and once daily thereafter for two days (Vancomycin and Streptomycin are potentially nephrotoxic).

For unreliable patients Penicillin-G as 600,000 units procaine and 200,000 units crystalline can be administered intramuscularly one hour prior to the procedure and once daily on the two following days with or without the Streptomycin depending on whether prophylaxis is being directed against the Strep. viridans or the Enterococcus.

It is important to include all procedures likely to cause a bacteremia in the prophylactic schedules. Dental debridement or "scaling" should be included as well as dental extraction or procedures likely to draw blood. Genito-urinary manipulation of any sort should receive prophylaxis. Surgery of the gastrointestinal tract, in particular of the colon and rectum, needs prophylaxis and this includes endoscopy when biopsy is to be performed. The author does not recommend prophylaxis for routine endoscopic procedures when biopsy is not performed. If, however, trauma occurs and any bleeding is present at the time of routine endoscopic procedure, patients with valvular heart disease should have a blood culture performed promptly (one is sufficient) followed by 250 mgs. of intramuscular Ampicillin and one gram of Streptomycin intramuscularly with completion of the Amoxicillin-Streptomycin schedule outlined above. Naturally, close follow-up is mandatory.

It also is recommend that valvular heart patients receive prophylaxis for Enterococcus as outlined above at the time of insertion or removal of an intra-uterine device (I.U.D.).[6] The same thing applies to pregnant women at the time of delivery.

In the event of a likely Staphylococcal infection which requires drainage such as an abscess or paronychia an injection of Nafcillin one gram intramuscularly should be given one-half hour prior to the incision and drainage. Cefazolin 500 mgs. intramuscularly can be used for those persons allergic to penicillin. Post-drainage therapy, of course, would be directed against the infection in the customary fashion.

It is very important to stress patient education regarding endocarditis and valvular heart disease. The patient must notify his physicians and dentists about the presence of valvular heart disease and must maintain a high degree of personal hygiene particularly of the teeth and gingivae. They should notify their physicians promptly if they develop an infection of any kind.

Rheumatic Fever

Prevention of rheumatic fever should be a relatively simple matter. It has been well-summarized recently.[7] Administration of 1.2 million units of long-acting Benzathine Penicillin-G once monthly will accomplish the task. Unfortunately there are many patients who will not accept this and therapy with Pencillin-G tablets 200,000 units two times daily has been the time-honored method. Sulfadiazine (500 mgs.) is an appropriate alternative for patients sensitive to penicillin. Unfortunately, patient compliance with the oral prophylaxis is poor.

Most of the questions which arise in rheumatic fever prophylaxis regard when to stop. In all probability cessation of prophylaxis may be stopped at the age of 21 in most patients who have never had carditis provided there has been no rheumatic activity in the preceding five years. Patients with a history of carditis or rheumatic valvular disease should probably continue to take prophylaxis until the age of 50. This is particularly true if children are born to the patients who then become school-aged children and there develops a greater probability of further exposure to the Group A Beta-hemolytic Streptococcus.

Patients who for one or another reason have discontinued rheumatic fever prophylaxis should be treated immediately upon the development of pharyngitis and/or tonsillitis. If at all possible throat cultures should be obtained prior to the institution of therapy. Whether or not an initial culture is obtained, a follow-up culture four days following the completion of a 10-day course of therapy is recommended. Sulfadiazine is not satisfactory therapy for Streptococcal pharyngitis even though it has been used successfully in the prevention of rheumatic fever.

It is realized that some of these schedules are somewhat rigorous and for outpatients a very definite inconvenience. Nevertheless, for the individual patient such a procedure is a relatively infrequent event and the pre-existing valvular heart disease represents such a clear-cut predisposing factor to endocarditis that the small burden of inconvenience far outweighs the possible ravages of bacterial endocarditis. ■

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Medicare-Medicaid Reform

HAROLD VAN MORGAN, *Atlanta**

ADMINISTRATION AND REIMBURSEMENT of the Medicare and Medicaid programs would undergo major reform under a recently introduced U.S. Senate Bill. The Bill, S.3205, "Medicare-Medicaid Administrative and Reimbursement Reform Act," was introduced by Senator Herman Talmadge, Chairman of the Subcommittee on Health of the Committee on Finance. The aim of the Bill as expressed by Mr. Talmadge is to make Medicare and Medicaid more efficient and economical.

In his introductory remarks to the Senate, Senator Talmadge emphasized that none of the changes proposed by the Bill is inflexible, and hearings will be held to determine modifications and refinements. A summary of a few of the highlights of the Bill follows.

Administrative Reforms

The new law would create within the Department of HEW several new offices and officers, including the Health Care Financing Administration, the Office of Central Fraud and Abuse Control, and an Inspector General for Health Administration. These officials would have responsibility and authority over audits, investigations and policy considerations of Federal health care programs under the Social Security Act with a primary emphasis on efficiency and economy of administration.

Provider Reimbursement Reforms

A uniform system of accounts and cost reporting would be established to determine reasonable cost reimbursement for hospitals under Medicare. Hospitals would receive payments under a formula applying an average per diem rate, regardless of actual cost. Comparable uniform reimbursement methods would be developed on a delayed basis for all other health facilities.

Practitioner Reimbursement Reforms

Reasonable charges for physicians' services would be determined by reference to separate statewide prevailing charge levels. The Bill would continue to apply an economic index for determination of increases in prevailing local charge levels, but no prevailing local charge level would be permitted to increase in excess of 150 percent of the statewide level.

To encourage agreements of physicians to accept assignments of claims, the Bill would create two categories of physicians under Medicare: "participating physicians" and "non-participating physicians." A "participating physician" would be one who agreed to accept all Medicare reimbursement on the basis of an assignment, with the reasonable charge, determined under Medicare, constituting the full

charge. A "non-participating physician" would not be eligible to accept assignments. Participating physicians would be allowed to submit claims on a multiple listing basis, and would benefit from an "administrative cost savings allowance" of $1.00 for each patient so listed. In addition, at least 50 percent of the estimated amount due on each multiple listing claim would be paid within five days of receipt of the claim. Generally, no cost savings allowance would be payable for services performed in a hospital or for laboratory or X-ray services.

In the case of hospital-associated physicians, the Bill would reduce the services eligible for reimbursement under Medicare through definitional revisions. The definition of "physicians' services" would be revised to exclude executive, educational, research services, and patient care services other than those personally performed or directed by the physician for the benefit of the patient and which are customarily and appropriately performed by physicians. Even more restrictive special definitions would apply to anesthesiology and pathology services. Changes would also be made with respect to the terms "medical and other health services," "reasonable cost" and "inpatient hospital services."

The Bill contains a new minimum account payable under Medicaid for physician services outside a hospital setting, fixed at 80 percent of the Medicare reasonable charge. It contains a provision for reimbursement for services furnished to a deceased individual in limited circumstances. The Bill also provides that the payment level under Medicare for inpatient radiological and pathological services would only be 100 percent of the reasonable charge if the physician was a participating physician.

Miscellaneous

With respect to long-term care under Medicaid, individual states might elect to include a reasonable profit factor in payments to skilled nursing and intermediate care facilities, and certification would be provided for "skilled nursing facilities."

In other areas, the Bill would provide for disclosure of certain business dealings of persons interested as officers, directors or owners of any entity that was a provider of health services, and would permit access to billing and payment records of independent laboratories and pharmacies. The Bill also extends Medicare coverage to ambulance services to the nearest adequately-equipped and staffed hospital.

In an effort to curb abuses, Medicare and Medicaid offenses which are now misdemeanors would be classified by the Bill as felonies punishable by up to 2 years' imprisonment and a $10,000 fine. ■

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* Prepared at the request of The Medical Association of Georgia. Mr. Morgan is an Associate in the firm of Powell, Goldstein, Frazer and Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

CORRECTION IN ANNUAL SESSION PROCEEDINGS

A typographical error was made in the report of the Councilor from Bibb County Medical Society, as printed in the June, 1976 issue of the *Journal of the Medical Association of Georgia*. This report appeared on page 188 of the proceedings. The first sentence of the second paragraph should read: "The Bibb County Councilor is pleased to report that the state of medicine in Bibb County at this time is healthy and vigorous with almost all our physicians *not* participating in government medical programs."

I've told this before . . . .

Ed. note: Author J. G. McDaniel provides another amusing story on characters in the barnyard. Contributions for this page are solicited from other physicians and their families, and should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.*

A Mean Rooster

SOME TIME AGO I was visiting in my old hometown in South Georgia. My brother Tom lives there, is a veterinarian and owns a small animal hospital. Between early morning and late afternoon fishing trips, I accompanied him occasionally while he made calls to see large animals on the farms scattered in Dodge County.

And that's how I happened to meet ol' man Humpback Stuckey.

He had a big spotted sow that couldn't birth her pigs, had called Tom and said that he and the sow had been up all night, and both were worn out. But Humpback did not look especially tired. He had a merry twinkle in his sky-blue eyes, was full of conversation, and I thought I could detect a faint odor of corn whiskey as he regaled us with farm stories while Tom was delivering the baby pigs with his forceps.

We were by the watering trough there near the barn and Tom was washing and cleaning his instruments when we noticed this big ol' Red Island rooster come prancing cautiously toward us. He would turn his head to one side and look at Tom out of one eye, then turn his head the other way and look at him out of the other eye. He had sharp spurs on each leg that were about two inches long. And as he strutted along he gave forth a low pitched, long drawn out warning sound indicating his displeasure.

When Humpback saw the rooster, he said, "Tom, if that ol' rooster tries to jump up on you, just knock the living hell out of him with your tongs and if you kill him it'll be all right with me. I wish somebody would kill him." He went on to say, "Ol' Red there is the meanest rooster in the State of Georgia, or even in the United States. He's not afraid of nothing and will jump on anything or anybody.

"You see that little white house down the road a piece? A tenant farmer lived there last year and had a big German shepherd. He wasn't a dog to go around looking for trouble, but he could always take care of hisself. He was up here one day and for some reason ol' Red got mad with him. Before the police dog knew what was going on, Red was on him like a flash, beating his eyes and face with his wings and hitting him a lick or two with his spurs for good measure. You see that high hedge down there at the lower end of the yard? Well, that police dog cleared that with a foot to spare.

"And then," ol' man Stuckey went on, "there was the time last fall that a book salesman come by. Left his car down on the road and walked up the driveway. He was a tall, skinny fellow and wore thick glasses. He was a-standing there by the steps, beating on the front porch floor and hollering, 'hello! . . . hello! . . . anybody home?' For some reason, Red didn't like this racket and after about the third or fourth 'hello!' Red flew up into his face and started battering him with his wings, knocked off his glasses and hit him a time or two with his spurs. You see that opening in the hedge there by the driveway? Well, that hole wasn't there until that salesman went through. The pore fellow couldn't half see without his glasses. I've got them laying there on the mantle in the parlor, but he never did come back for them."

We were getting ready to leave when Tom asked, "Didn't he get mixed up with a hawk one time?"

"Oh, yeah," said Humpback. "In fact, you was out here, Tom. Don't you remember? That old black cow over yonder in the pasture was sick." Then he turned to me and said that Tom had finished doctoring the cow and was washing his hands there by the well and he had gone into the house to get Tom a clean towel.

"All at once," Humpback said, "I heard the chickens let out scary squawks. They panicked and ran for cover in all directions, under the house, in the barn, in fact, under anything that they could find. All but ol' Red. He just stood there in the middle of the yard. All of a sudden there was a 'swish' and out of the sky comes this big hawk, the biggest one I've ever seen. At first I thought it was an eagle, but anyway, he hit ol' Red's back, knocked the daylights out of him and sunk his claws in good. You never heard so much flopping of wings and commotion as the hawk struggled to get off the ground. He finally made it, taking ol' Red with him. I turned to Tom and said, 'Well, I'm glad he's gone, but I never thought a hawk lived that could do it. I'll say one thing, though, that hawk is sure going to have one tough piece of meat.'

"Then Tom left and I went in the barn and got some good hay for the cow who felt better by now. I was standing there petting her, because she was tired and sick, when I heard the chickens carrying on again and running in all directions. I looked up and couldn't believe my eyes. The hawk was bringing ol' Red back home and I watched him gently set him down out there and slowly take off.

"I figured the hawk musta took ol' Red over to one of those open fields, set him down and was going to give him the real business before settling down to a big meal. As soon as he turned, the old rooster let loose, though. Red musta jumped on him and whupped the living hell out of him, whupped him so bad that he made the hawk bring him back to where he got him from . . . like I told you, he's one mean rooster."

Tom had already put up his instruments, and I didn't crack a smile, just looked down and shook my head from side to side and started to leave. Humpback took Tom by the arm and said, "Tom, I don't think your brother believes this story." Then he turned to me and said, "Doc, I tell you what I'll do. I'll step yonder to the crib, get some corn, toll ol' Red into one of the stables and close the stable door. Then you can go in the stable and catch him and if you ruffle the feathers back on his back, you'll see six to eight scars where the hawk's claws dug in." With that he started walking toward the corn crib.

"Never mind . . . never mind, Mr. Stuckey," I said hastily. "I believe you, I believe every word you said. And if 'push comes to shove,' I think I would swear to it!" ■

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the association
the association
the association

NEW MEMBERS

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9 Medical Arts Center, Savannah 31405

Malone, Ellis L., Cobb—Act—I
Cobb Internal Medicine
3910 Austell Road, Austell 30001

SOCIETIES

Guest speaker for the May meeting of the **Baldwin County Medical Society** was Dr. Sophia B. Bamford of Washington, speaking on "The Application of Exfoliative Cytology to General Practice." The society voted to contribute funds to a memorial fund for Charles Fulghum, M.D.

The **Bibb County Medical Society** plans no July meeting but will have a picnic Thursday, August 5 for the membership. In September, candidates for state and national offices from the area will be invited to speak, along with a representative from Smith Kline & French Laboratories, Mrs. Irene Lump.

Former Secretary of State Dean Rusk gave an optimistic report on America's future at the joint meeting of the **DeKalb County Medical Society** and its Auxiliary in June. Mr. Rusk, now with the University of Georgia, said the youth of today can be depended upon to make the world tomorrow a better place in which to live. A Bicentennial theme was followed for the July 19 meeting of the society which included entertainment by a barbershop quartet. The society has selected Luther Vinton as its representative to the board of Metropolitan Emergency Medical Services.

The **Georgia Medical Society** met in June with Thomas M. "Buddy" Smith, Jr., defense attorney for The St. Paul Companies in the Atlanta area, who discussed malpractice litigation. The society recently participated in a project to screen high school seniors for hypertension and positive urinalysis tests.

Several members of the **Medical Association of Atlanta** were featured in the June *Atlanta Medicine* for their interesting or unusual hobbies which included bee keeping, restoring old homes, playing classical guitar and collecting circus memorabilia.

The **Muscogee County Medical Society** was visited in May by Christopher Williams, M.D. of St. Marks Hospital in London, a world-known colonscopist. Dr. Williams spoke to the society, presented programs for the medical-surgical-pathology conference and conducted medical grand rounds. He lectured at the Medical Center and performed a colonoscopy demonstration.

PERSONALS

First District

Carl Rankin Jordan of Savannah has been certified as a diplomate of the International Board of Proctology, specializing in colon and rectal diseases. The certificate will be presented next February at the annual congress in Sydney, Australia.

Second District

W. O. Holloway of Tifton spoke for doctors in Tift County approving the purchase of an emergency telemetry system for cardiac patients in the area. Dr. Holloway is chief of staff at Tift General Hospital with which emergency medical technicians will be in touch as they transport cardiac patients and begin emergency treatment.

Fifth District

Jonne B. Walter, M.D., director of pulmonary rehabilitation at Georgia Baptist Medical Center coordinated a one-day workshop in late May on rehabilitation of the patient with chronic obstructive pulmonary disease.

A. H. Letton of Atlanta was the guest speaker at the dedication of Duke University's Cancer Center Out-Reach Program. Dr. Letton also spoke at the Kentucky Surgical Conference on Breast Screening and Treatment of Minimal Care of the Breast, and will lecture in Switzerland and Russia on breast care.

Newly elected chairman of the Department of Medicine at Georgia Baptist Medical Center is **Richard E. DuBois,** who is replacing **John S. Atwater.**

Coordinating the Spring Seminar for the Atlanta Society of Pathologists was **Robert E. DeLashmutt** of Atlanta.

John Godwin has been re-elected as treasurer of the Society of Surgical Oncology and was recognized by the Planned Parenthood Association for his many cytology studies conducted in cooperation with that group.

J. A. Bordon recently addressed anesthesiologists meeting at the Washington, D.C. Medical Center and demonstrated new techniques in open heart surgery anesthesia.

Sixth District

The Library of the new Monroe County Hospital will be dedicated to **George H. Alexander,** who was MAG president from 1965-1966. Mrs. Barbara Fisher, nursing director and head of the library fund drive, said,

"Dr. Alexander has been in practice locally more than 45 years. He was a driving force in the original hospital and he has followed progress all the way."

Eighth District

Ollie O. McGahee of Jesup, one of six physicians in Georgia on the Georgia Heart Association's advanced cardiac life support facility, is training area medical personnel and laymen in emergency skills needed for heart attack, electric shock and drowning. A local company, the Rayonier Foundation, has provided training mannequins for use in the program which will involve area emergency medical technicians and mill personnel.

Ninth District

P. K. Dixon participated in dedication ceremonies in late May for the new Lumpkin County Hospital, which will serve a three-county area.

Tenth District

Curtis H. Carter has been named professor emeritus of medicine at the Medical College of Georgia in Augusta.

DEATHS

Carl Cato Aven

Carl C. Aven, 89, who established in 1955 the Aven Citizenship Award given each year by the Medical Association of Atlanta, died June 1 in Atlanta. He himself was a recipient of the Award 11 years after its establishment.

Dr. Aven had practiced medicine in Atlanta 45 years, and was well known for his efforts in the field of chest diseases and tuberculosis. He worked to establish tuberculosis facilities at Grady Hospital and was active in the local, state and national tuberculosis associations.

The Parrott, Georgia native attended Atlanta School of Pharmacy and received his medical degree from Emory University in 1910. He later taught at Atlanta College of Pharmacy, Southern Dental College and Emory. After his retirement from active practice in 1955, Dr. Aven worked in the area of preparing others for retirement and was a delegate of the 1971 Conference on Aging.

He was a past president of the Medical Association of Atlanta, past president and chief of staff at Georgia Baptist, and a member of the board of regents for the American College of Chest Physicians.

Active in the community, Dr. Aven was a past president of the Atlanta Community Planning Council, past chairman of the Community Chest Council. He had been chairman of the Senior Citizens Committee of the Republican Party of Georgia, was on the Atlanta City Council, and the State Board of Public Welfare.

Survivors include his widow, the former Mary Boswell; sons, Gordon W. Aven of Atlanta and Carl C. Aven, Jr. of Athens; sisters, Mrs. Walter L. Smith and Mrs. Collins Christian of Dawson.

William L. Cousins

Retired Atlanta physician William L. Cousins died June 6 at the age of 75. He was a graduate of the Atlanta College of Physicians and Surgeons and had served on the staffs of Crawford W. Long, Georgia Baptist and Jesse Parker Williams hospitals.

Dr. Cousins is survived by his widow, the former Edith Holland; daughter, Mrs. James Carroll of Tucson, Arizona and son, W. L. Cousins, Jr. of Tucker.

James Myers Hicks

Brunswick physician, James Myers Hicks, died May 15. He was 70. Dr. Hicks had practiced in Brunswick since 1940, though serving in the U.S. Air Force from 1942 to 1946. He was a graduate of Furman University and the Medical College of South Carolina. His residency was served at Roper and Riverside Hospital in Charleston, S.C., Duke University Hospital, and Episcopal Eye, Ear, Nose and Throat Hospital in Washington, D.C.

Dr. Hicks entered practice in Florence, S.C. before coming to Brunswick. He served as a federal aviation examiner surgeon for the Southern Railway Association and a member of the Brunswick Rotary Club.

Dr. Hicks is survived by his widow, Mrs. Walker Dell Sellers Hicks; daughter, Mrs. Ranson D. Braswell, Jr. of Chattanooga, Tenn.; two sons, James M. Hicks, Jr., of Atlanta and Albert Sellers Hicks of Conyers; sister and two brothers.

Simon Krantz

Simon Krantz, who pioneered the field of therapeutic radiology in Georgia, died March 14. He was born in New Haven, Conn., and was graduated cum laude from Yale University. His medical degree came from Bellevue Hospital Medical School. He trained at the Cancer Institute in New York, Grace Hospital, New Haven, and Bellevue, then came to the Veterans Administration Hospital in Atlanta.

During his 40 years at the hospital, he established the tumor registry and tumor clinic, and was consultant to the Steiner Cancer Clinic associated with Grady Hospital.

He served as a founding member of the Georgia Radiologic Society and professor of radiology at Emory, and was a Fellow of the American College of Radiology. Dr. Krantz recently was honored with the Distinguished Career Medal and Citation of the VA.

Walter August Schimmel

Family physician Walter August Schimmel of St. Simons died May 25 at the age of 73. Dr. Schimmel was born in Wisconsin and graduated from the University of Iowa, receiving his medical degree from Rush Medical College of the University of Chicago. His private practice in Dundee, Ill., ended with his retirement six years ago, when he moved to Georgia and worked for the Public Health Service.

Dr. Schimmel was a veteran of World War II, serving in the U.S. Army Air Corps and retiring with the rank of lieutenant colonel. He was a member of the Board of Trustees of Carthage College in Kenosha, Wis., was chief of staff of Sherman Hospital and a member of the staff of St. Joseph Hospital in Elgin, Ill.

Survivors include his widow, Mrs. Virginia Redding Schimmel; daughter, Mrs. Ann McInturff of St. Simons; three sons, Douglas Wayne of Chicago, Ill., David Walter of Alexandria, Va. and John Stafford of Racine, Wis.; brother, Erwin Otto Schimmel of Whitewater.

J. Gregg Smith

South Carolina native J. Gregg Smith, 84, died May 2 in Forsyth, where he had lived 10 years. He was retired from the U.S. Navy for which he had served 30 years. He was a member of the Forsyth United Methodist Church, was a Mason and a member of the Macon Elks Club, the American Legion, Lions Club and a life member of the Rotary Club.

Dr. Smith is survived by his widow, Mrs. Annie Laurie Maynard Smith of Forsyth; son, Carver N. Smith of Hanau, Germany; and daughter, Mrs. Carolyn Smith Anderson of Seal Beach, Calif.

William Richard Snelling

Columbus physician William Richard Snelling died March 15 at the age of 69. Dr. Snelling was born June 19, 1906 in Richland and was graduated from the Medical College of Georgia in 1931. His internship was served at the University Hospital in Augusta from 1931 to 1932, after which he did a surgical residency at the Station Hospital of Ft. McClellan, Ala. from 1935 to 1937.

Dr. Snelling served in the U.S. Army from 1941 to 1946, then moved to Columbus. He is survived by his widow, Julia Snelling; and three children, Jane, Val and Bill Snelling.

Loyd Yeargin

Loyd Yeargin, 58, of Dalton was killed May 24 when the light plane he was piloting crashed near Carnesville. At the time of the accident Dr. Yeargin was transporting his brother, Wallace Yeargin of Hartwell, back to Dalton for medical treatment. The brother also was killed in the crash.

Dr. Yeargin was born in Hartwell and received his medical degree from the Medical College of Georgia. The family physician had been practicing in Dalton since 1951. Dr. Yeargin was a member of the Flying Physicians Association, was a Diplomate of the American Academy of Family Physicians, and was a member of the Pan American Medical Association Division of Family and General Practitioners.

He is survived by his widow, Mrs. Ruby Jones Yeargin; daughter, Mrs. Greg Sims; three sons, Randy, Steve and Gregg Yeargin, all of Dalton; two grandchildren.

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

The Administration has submitted an "encouraging report" to Congress on the Professional Standards Review Organizations (PSRO) program, but confessed at the same time that lawmakers should not expect too much in the way of cost savings.

Louis Hellman, M.D., head of the Health Services Administration, told the House Ways and Means Oversight Subcommittee that "important progress has been made." He said in the 203 designated PSRO areas there are 65 conditional organizations performing review and another 55 in the planning stage. By the end of the fiscal year, 120 conditional PSRO's will be in operation reviewing some 3 million hospital admissions, he said. More than 106,000 physicians are now members of organized PSROs according to the Health, Education, and Welfare Department official.

Dr. Hellman said the primary purpose of the PSRO program is quality assurance and that cost-effectiveness was a secondary objective. "The quality assurance activities of PSROs may increase the utilization of some services while decreasing that of others," he testified as—"a word of caution on expectations of a PSRO's ability to control expenditures."

At the same time, however, the Subcommittee received other information from HEW suggesting substantial economy benefits from PSROs. In response to a subcommittee questionnaire, HEW said in some areas the average savings has been on a one-to-four (cost to savings) ratio.

Subcommittee Chairman Charles A. Vanik (D-Ohio) said "we would like to discover whether the Congressional expectation that PSROs will hold down costs is reasonable, since improved quality of care is often incompatible with lower costs. If the Congressional goal of holding costs through PSROs is not reasonable, then we must give renewed attention to finding other types of cost controls."

Challenging Federal Regulations

Legislation requiring the government to give affected parties more rights to challenge and make recommendations on proposed federal regulations has been endorsed by the American Medical Association.

Specifically backed were bills introduced in the House by Rep. Thomas Kindness (R-Ohio) and in the Senate by Sen. Charles Mathias (R-Md.) providing remedial changes in the Administrative Procedures Act aimed at opening up regulatory procedures to assure that the government doesn't overstep Congressional intent or ignore it.

Raymond T. Holden, M.D., Chairman of the AMA's Board of Trustees, told the Senate Judiciary Subcommittee that such legislation "is a welcome move toward rectifying the many abuses which have arisen in the rule making process of administrative agencies."

This seems to have been especially true in the health agencies, according to Dr. Holden, who said that health regulations often have resulted in programs "unrecognizable in the original law."

At the same time, the AMA official said legislation to require complicated governmental review of regulations could "create a mechanism which could strangle the good intentions of remedial legislation."

Clinical Laboratories

The Senate has passed 64-11 a bill broadening federal authority over clinical laboratories to include those engaged in intrastate operations and giving the government firmer standards control.

Under the legislation, HEW theoretically could apply

the controls to individual physicians' offices. The pertinent provision states that the HEW Secretary "may exempt" such offices. As a condition of such exemption, physicians who use their offices as labs as an adjunct for treating their own patients would have to describe the qualifications of non-physician personnel who do lab work, how much they do, and the score each shows in any proficiency testing.

Sen. Carl Curtis (R-Neb.) complained that "here the government is reaching down to the country physician's office. . . . I say that we are removing from people the medical services that our society now provides by giving the federal government jurisdiction over them."

The bill, which now goes to the House where similar legislation is before the House Health Subcommittee provides:

Federal licensing of all clinical laboratories. HEW would set standards and enforce them itself or delegate enforcement to states having statutory programs meeting federal criteria. Private nonprofit accrediting groups could be used to help enforce standards if they meet federal requirements but no exemption from licensure to privately accredited laboratories is provided.

An advisory council with membership set at 12 persons, to include representatives of nationally recognized laboratory-accreditating bodies, directors of state laboratory-licensing programs, members of the public, and not more than three persons who are owners, operators, or directors of laboratories.

Costs of NHI Plans

A Rand Corporation study says the amount people would have to pay in taxes under the disparate national health insurance (NHI) proposals before Congress wouldn't vary much and suggested this opens the door to compromise.

The study, financed in part by the government, was written by Bridger M. Mitchell, senior Rand economist, and William B. Schwartz, M.D., a Rand consultant and chairman of the Department of Medicine, School of Medicine, Tufts University.

The report said that the Administration's CHIP approach in its 1975 NHI bill provides a "surprisingly small" saving to middle and upper income taxpayers over the 1975 compromise Kennedy-Mills plan, although both provide essentially the same services.

The old Nixon Administration bill and the defunct Kennedy-Mills bill each would require total revenues of some $45 billion to fund the health care of people under 65. The Rand team said the labor-supported Kennedy-Corman proposal would require $68 billion, and the Long-Ribicoff bill, $16 billion.

Financed by payroll and income taxes but requiring no payments to hospitals or doctors by patients, the Kennedy-Corman bill, despite its higher cost, would impose virtually the same total cost for health care on families earning under $15,000 as the Administration and Kennedy-Mills bills, the report said.

But to raise the extra $23 billion it would cost, the Kennedy-Corman bill would impose sharply increased taxed on upper income families—as much as $1,000 a year more than under the Administration and Kennedy-Mills bills for a $40,000-a-year family. ■

Classifieds

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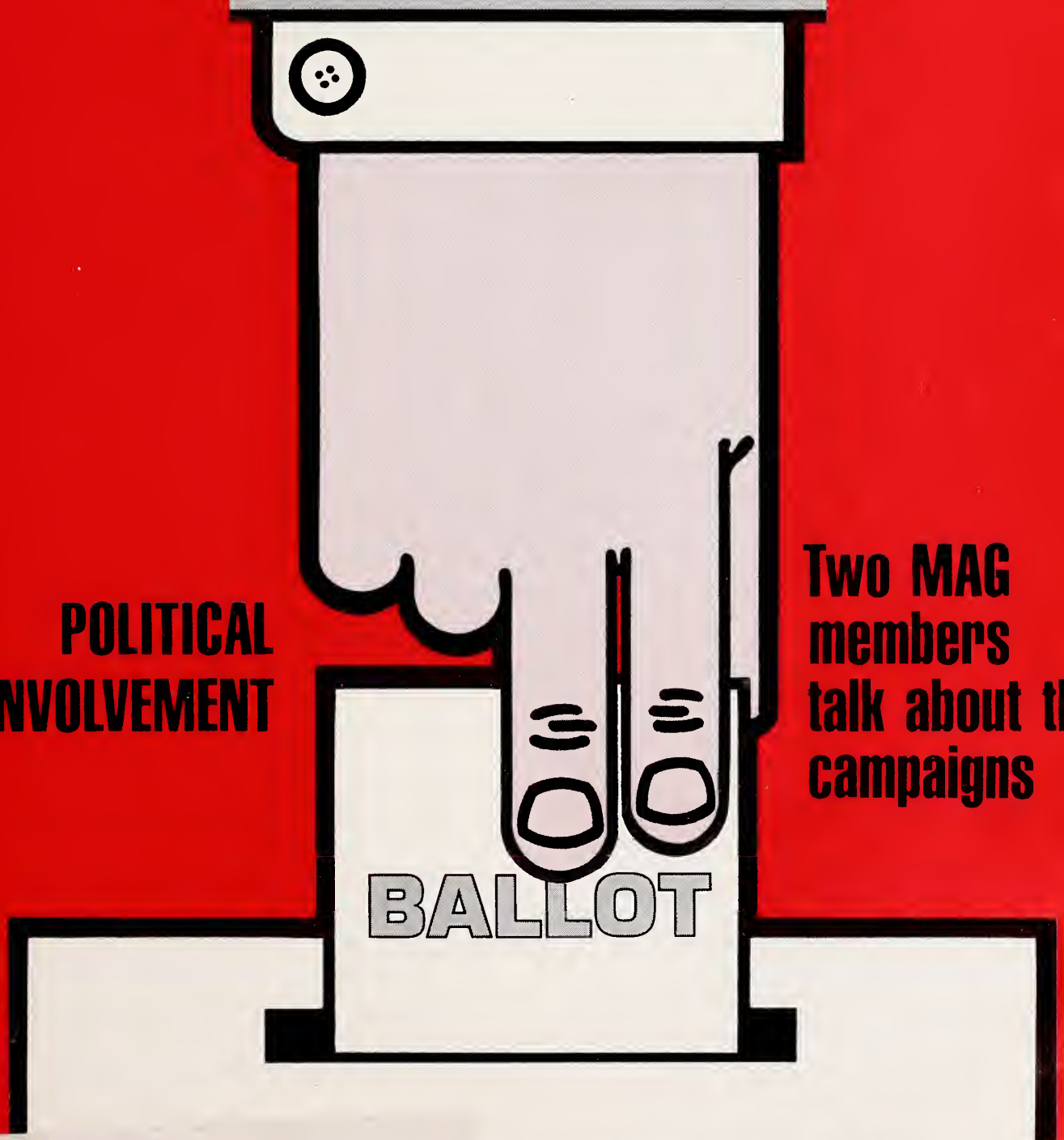
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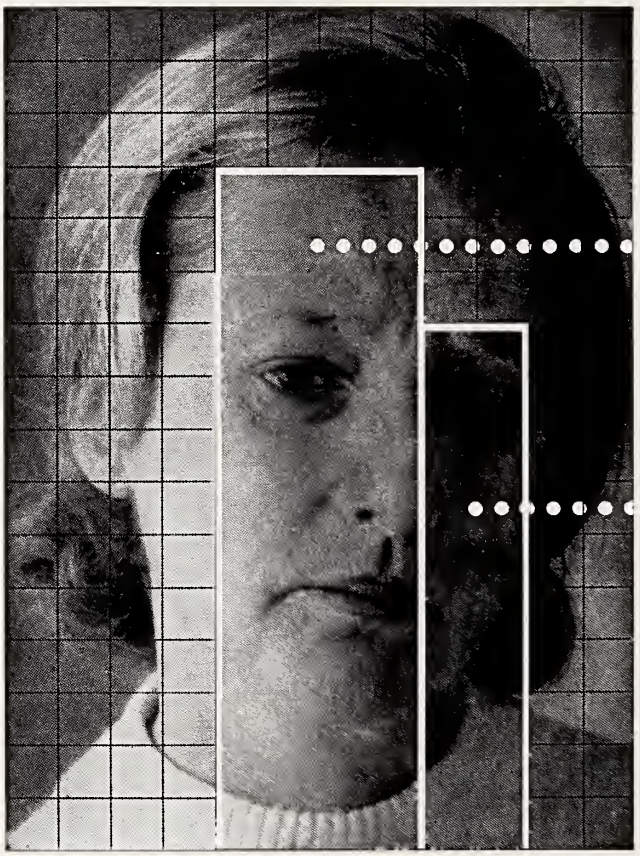


POLITICAL INVOLVEMENT

Two MAG members talk about their campaigns

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THE COVER

At least two Georgia physicians with more than a casual interest in politics have suspended their practices to run for office this summer. Beginning on page 311, read why C. C. Moreland, M.D. and J. Roy Rowland decided to "get involved," what they hope to accomplish, and their advice to other physicians who might contemplate such a step. A related editorial by J. Dan Bateman, M.D. on the activities of GaMPAC begins on page 325.

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Political Involvement

An Interview With Candidate C. C. Moreland, M.D.

What is the background of your interest and experience in politics?

My family was involved in politics all of their lives. My father was a member of the Democratic Committee of Towns County so I was familiar with the political process as I grew up.

Ten years ago I ran for office in Walton County and served one term in the Georgia House of Representatives. I found that the demands of my medical practice would not allow me to adequately serve the county and the state legislature for 40 days and also maintain a medical practice at the same time. Since then it has been in the back of my mind to run again. I was interested in running for Congress in the next two to four years. Stephens (Robert G. Stephens, Jr., Athens) was approaching retirement age, and I planned to run then. He announced this year that he was retiring early, and I made up my mind the same day that I would run. Six months prior to the time he announced he would retire my wife and I have started making plans for a campaign. His withdrawal and announcement that he would not run shoved us into the campaign. I announced to my staff that I was taking a leave of absence from my practice.

When you served in the Georgia House of Representatives did you have any surprises about the processes of government?

I had misconceptions about how effective I could be. I didn't anticipate that the demands of my practice would continue during the 40 days of the legislature. I thought my patients would accept another physician readily, but they did not. They would call me off the floor of the House, tell me about their

C. C. MORELAND is a family physician who has been practicing medicine in Walton County for 16 years, first in Loganville and then in Monroe.

He was born in Hiawassee, served four years in the U.S. Army, then attended Young Harris Junior College and North Georgia College from which he was graduated with honors in 1955. Dr. Moreland attended the Medical College of Georgia from 1955 to 1959, was graduated, and served a one year internship at the Spartanburg, S.C. General Hospital.



He ran for the Georgia House of Representatives in 1965 and won, beating an incumbent. Dr. Moreland served on the House Ways and Means, University and Health and Hygiene committees. The demands of his practice and scarcity of doctors in Walton County, compelled Dr. Moreland to resign his seat and return to full time practice in 1968. Since then he has served several terms as chief of staff at Walton County Hospital and founded a new medical clinic in Monroe.

In his current campaign, he lists his priorities as "the economy, reckless government spending, reform of heatlh care and welfare programs, an agricultural policy to help the small farmer and representation of the people and small business over representation of big business and special interest groups."

Dr. Moreland is married to the former Callie Shepard of Social Circle and has four children ranging in age from 11 to 24.

problems and that their children were sick. I told them other physicians were taking my calls, but they didn't want to see them. When I got a call I didn't know if it was a constituent or a patient, and I had the responsibility of taking care of them.

I felt I had to make a disposition of the problem. It was a terrible situation trying to serve the people of Walton County as a legislator and their physician.

I was not surprised at the methods by which programs were made in the legislature, I was familiar with the legislative process.

As a physician, are there advantages or disadvantages in running for office?

I think it is an advantage to run as a physician, as a family physician in particular. No other person in the community is trusted and respected as much. You have a following even if your personality is not consistent with the political personality. That is, you can't be an introvert, as many physicians are. You have to have an outgoing personality.

Politics is a dirty word to a lot of people. We tend to let the media put politics in a bad light, because its orientation is toward bad news because it is readable and interesting. We tend to forget about the very dedicated men in politics that serve their country and serve the public 12 to 14 hours a day. We need to concentrate more on propagating the good in our form of government. Everything in Washington is not sex and corruption.

Our good servants in Washington should be given equal treatment with those who are doing bad things, so that the respect of the public can be regained.

How would you advise freshmen politicians to avoid getting themselves involved in an unethical situation?

I think it is just good basic common sense. Don't allow people to show you only one side of an issue. You should consider every angle, consider the people that are trying to show you the angle and what their interest is in the particular issue. People with ordinary intelligence can make an effective decision.

Could involvement in politics mean a financial burden for physicians?

Most physicians would make more money in practicing medicine than in Congress. However, the median salary of family physicians is less than the congressional salary. But with the standard of living and high cost of living in Washington, the income would be relatively the same as far as the overall picture. Money is not really a concern when you are running for Congress as a physician. You are interested in representing human needs and people needs in this country, things that are overlooked because there is no lobbyist for people needs.

Do you feel there is a predominance of lawyers in Congress and is this one reason you as a physician have chosen to run?

We need a good cross section of minds of this country. If we have good input from every sector of life, farmers, businessmen, doctors, lawyers, people will benefit from the minds of every walk of life.

What were your special concerns when you served in the Georgia General Assembly?

That was 10 years ago. I was on the Health Committee, the University of Georgia Committee and the Ways and Means Committee. I thought these were important. Primarily I was concerned with people problems, the aspects of human life that a physician already is trained for. The health of the individual is related to the social conditions of the patient and the economic conditions of the patient, and the other aspects of life that control the patient's life. So all are interrelated. You are not just concerned with health needs, also emotional needs. And the physician works with the total human being.

Are you running now on a national level because you feel you can be more effective there?

Most of the problems that affect the country from the standpoint of people's needs originate in Congress.

How does your wife feel about this campaign, and what sort of a staff do you have?

My wife is very excited about the campaign in general. I couldn't run it without her. We have a person to person campaign, she takes one side of the street and I take the other. I have a big volunteer staff, not many paid individuals. I just hired a campaign chairman, Ray Abernathy, a couple of weeks ago.

It's like a game of chess trying to figure out the weaknesses of the other candidates and their strong points. You take advantage of their weaknesses and block out their strong ones.

How would you advise other physicians to get involved in politics if they do not want to run for office?

Physicians underestimate the political power they command. They should become more active by supporting the candidate that represents their philosophy of government and personal views of life. When a patient comes in to see them they should have a

poster in every examining room and waiting room. When they write a prescription they should pass along with it the candidate's card saying they know him and support him. Just a friendly gesture. People respect the opinion of their physician.

In the whole 10th District with 500 physicians within a six months time they could see nearly every voter and encourage him to vote for the man of their choice. Most physicians are not taking an active part in deciding their political fate in this country. I hope they become more conscious of what is going on in government and lend their efforts.

How long do you plan to be involved in politics and hold office?

As long as the people continue to elect me. I hope a lifetime. I see it this way, as a physician I am serving only a few people each day in Monroe. In Washington, D.C. I am able to serve hundreds of thousands a day. People to represent the views of the people are desperately needed in Washington at this time.

Physicians in the community have been most kind in accepting my patients and dividing them among them. We have a good number of physicians in the area now, including specialists, to accept the responsibility of my patients.

What is your stand on national health insurance and advertising by physicians?

I am opposed to national health insurance and socialized medicine, period. I think advertising would be bad for the medical profession. Advertising can be a cheap way to sell a lot of poor products by high pressure media techniques. It would be degrading to the profession.

A Conversation With Candidate J. Roy Rowland, M.D.

What experiences led to your decision to run for political office?

Approximately a year and a half ago, it became evident to me that the rapidly expanding federal bureaucracy would eventually lead us to a leviathan society. It further appeared that the principle thrust to achieve such a society was in the field of medical care. This started back in 1966 with such programs as Medicare and Medicaid; in 1970 federally funded health maintenance organizations; in 1972 Professional Standards Review Organizations, in 1974 Public Law 93-641; in 1975 capitation grants with the payback provision, the National Health Education and Disease Prevention Act, and all along the continued effort to enact a national health insurance program.

It was my feeling that those in the professions of medicine, pharmacy, dentistry, and allied professions could, through a coalition, bring this trend to a stop. It was amazing how uninformed most people in these professions were concerning legislative activity in this area. With the help of others, I organized and incorporated a committee, the Committee on National Trends, Ramifications and Origins of Legislation (CONTROL), whose purpose was to arouse interest by apprising the professions of activity and portent in health care legislation. The concept was well accepted, but the involvement had been less than I had hoped for, insofar as I could tell.

I am not sure just when I decided first to seek political office, but I think it was around the first of this year. Although what I had been doing with the Committee had been very satisfying, it seemed that there was something more that needed to be done. It seemed to me that the people who were in the greatest jeopardy at this particular point from an expanding federal bureaucracy were people in the middle and lower middle class economically. Many

J. ROY ROWLAND is a family physician who has practiced in Dublin since 1954. He grew up in Middle Georgia, winning recognition as a lettered football player and Eagle Scout. His Wrightsville high school classmates named him "most outstanding all around student."



He served with General Patton's Third Army during World War II, then went on to the University of Georgia and the Medical College of Georgia. His internship and residency were at Macon Hospital.

He is a Diplomate of the American Board of Family Practice and a member of the Pine Forest Methodist Church. Dr. and Mrs. Rowland, the former Luella Price, have three children and three grandchildren.

of them were being forced to become dependent on government welfare programs in part because of inflation. Inflation, of course, comes about because of deficit spending by our government. For some reason, I felt myself pulled closer to these people, and any personal problems that I may have had because of increasing government intervention paled in the light of what these people were experiencing. For several weeks now, I have been talking with people in the 119th District and this has been one of the most rewarding experiences that I have ever had.

What are your goals, if elected?

I am not sure just what I might be able to accomplish if I am elected. The problems that we face insofar as the survival of our republican form of government is concerned can, in my opinion, be attacked at a state level as well as a national level. Almost everyone with whom I have talked is very adamant in wanting to stop increasing federal control. It remains to be seen how much they want it stopped when they realize it may to some extent effect their person, income, or way of life, at least for a period of time. I believe that greed and over-indulgent self-interest are the prime causes of moving us into the precarious situation in which we now find ourselves.

How will you handle your office practice?

I am in a fortunate position insofar as my patients are concerned since I am in a group practice, and my four partners will care for my patients while I am away.

What hardships might a physician face who decides to run for office?

Physicians are the most respected group of people in our society at this time. I can see very little insofar as disadvantages are concerned in entering politics. There will be some loss of income, some loss of material things, some loss of spare time that has been devoted to personal pleasures, but these are far outweighed by the satisfaction of accomplishing something for our society. To do this is not only a debt that we owe to our forefathers, but it is a duty that we have to our posterity. Our effectiveness is limited only by our individual initiative and aggressiveness.

I was talking recently with an older person who has been involved in politics in the past but is retired now. I have come to have much respect for him. He told me it was his belief that one has to be called to enter politics, and I believe this is so. I do not know what the future holds insofar as my continued involvement in it is concerned.

For those physicians who do not want to seek office themselves, the most important thing that they can do is acquire some knowledge about what is happening in our state legislature and in Congress. An uninformed person is for the most part, ineffective. An informed physician could be more effective than anyone else that I know of. When a physician says he does not have time, he is only rationalizing.

What is your position on the major areas of concern to physicians?

I am opposed to national health insurance, advertising by physicians, federally funded health maintenance organizations, federally funded medical care programs, and physicians' unions. Medical care should be provided and regulated on a local and state level for the indigent. Deficit spending should not be incurred in providing these programs. Physicians have a responsibility to the people in the community in which they live and this should be the basis upon which medical care for the indigent is provided. ■

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This approach requires that in considering the etiology we study the antecedent conditions that militate toward excessive ingestion of alcohol.

Alcoholism, the "Disease"—A Global Approach

HENRY A. SELVEY, M.D., F.A.B.P.N., *Atlanta**

As Talbott and Gander[1] in their recent article (September, 1975) in this journal point out of alcoholism, it is a disease and rightly deserves that designation. From the well defined clinical course[2] and recognized pathological sequelae an entity designated "alcoholism" is regretably clear even if the situation is not as straight forward as implied.[3, 4] However, to maintain that ". . . undeniably obsolete is the historical premise that this is basically a psychiatric disorder,"[1] while perhaps well meant in its intent to focus attention to medical aspects of the condition is not only unjustified but may well overlook major problems in managing the disease.

One cannot deny that ingestion of certain substances as found in picas lead to well defined pathological conditions and that these must be medically managed. Nonetheless, all management must include efforts to stop the ingestion of the toxic substance and these efforts are psychological in all cases either through environmental manipulations or through more psychotherapeutically oriented approaches. Even if, and the burden of proof lies with those who claim this, there were genetic-biochemical predisposition either for the establishment of sequelae to alcohol ingestion or for the establishment of a craving for this drug, still efforts to reduce or stop ingestion of it must include psychological approaches to the problem. It is clear, for example, that while a reduction of alcohol intake may be achieved by the addition of antabuse to the therapeutic regimen, this actually can be rather dangerous in the absence of sound psychotherapeutic intervention. Rather than concentrate on the pathophysiology of alcoholism once excessive alcohol has been ingested would it not be wise to include major concern with why the toxin was ingested in the first place, why it continues to be ingested and what conditions support this from environmental sources? The tissue disease is what happens after the trigger has been activated and to forget this may effect more harm than good.

Numerous Factors

To propose an etiology for alcoholism at this day and age is simply not how the condition is understood. As general system theory teaches us some entities are understood more realistically as simply the resultant of many possible forces and not necessarily the same forces in all instances. This seems certainly true of alcoholism as attested by current literature on the subject.[5-7] We now think of predisposing factors within the individual, historical as well as possibly biological, current factors in the individual's life, and finally the socio-cultural matrix within which an individual finds himself. That constellations of etiological factors exist in all cases of alcoholism is now assumed and hardly anyone concerned with the management of the alcoholic, including those of us who do psychotherapy exclusively, imagine there to be a unitary psychological trait such as "oral fixation" to explain the condition. Granted, it is recognized that there are personality features common to many who manifest the disease, but this neither determines an approach to an individual with the problem nor to the problem in general.

Talbott and Gander seem to have considered the "disease" of alcoholism primarily as "that which results from alcohol ingestion." It would seem more appropriate to consider the global process—that which an alcoholic individual manifests both psychologically as well as physiologically and how he got to be that way. This approach requires that in considering the etiology we study the antecedent conditions that militate toward excessive ingestion of alcohol. This extends the possible facets for intervention to include much more than merely the pathophysiologic derrangement indisputably causing a part of the condition. Our interventions then become medical, so-

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cial, psychological and possibly even cultural.

We attempt to understand what within the individual, what within his society and what within his own environment system (usually his family) earmarked him for selection as an alcoholic. We attempt to understand what function he serves within the system and what alternatives are available to the system to maintain its vitality without the alcoholic individual having to maintain a role that includes alcoholism. We attempt to understand what behavioral patterns (roles) of others within the system can support this change. We are well aware that very strong forces are being dealt with through the behavioral repertory of the alcoholic which includes the development of serious and life threatening disabling medical sequelae. Many times it becomes clear that suicidal intent underlies the addiction and that this intent is shared with a larger system that is interested, for example, in killing its dependent strivings. Alcoholism may be an adaptation of despair not only for the individual but for the family or society as well. To recognize this would encourage remedial intervention at every possible point within the system. Clearly this would include shifts in attitudinal patterns within the individual, the family and society as well.

Ambivalence Toward Alcohol Use

Conflicting social attitudes about and ambivalence toward the use of alcohol within a culture and especially this culture have been mentioned as possible social determinants of alcoholism.[8, 9] In this society the ambivalence usually is concerned with conflict about dependency and even more basically conflict about the attainment of pleasure. Our society with its strong work ethic has at the same time a strong drive toward "the pursuit of happiness," two attitudes that often become the opposite poles of real ambivalent struggle. That this struggle is often involved in the alcoholic's despair is all too often clear within the family system or the individual himself and usually both.

Horton[10] in a cross cultural study confirmed that alcohol use is associated with a release of sexual and aggressive impulses and that it is further associated with high anxiety levels that alcohol is used to decrease. Where a society has ambivalent attitudes towards sexual and aggressive impulses the release of these should cause anxiety. If alcohol under such circumstances is to be used to decrease anxiety the only way a society can then maintain the use of alcohol as a releasing agent is to give intoxication an institutional status of irresponsibility. This status allows the alcoholic to satisfy needs without feeling responsible and therefore anxious regarding social approbation but then requires those in the system to be responsible for him. This clearly requires an interaction with the system he is a member of and illustrates how the system plays a reinforcing role by relating to the alcoholic in a specific manner. Many of us enjoy the institutional irresponsibility of intoxication when it is we who can be irresponsible but often then resent it when the shoe is on the other foot. The alcoholic may avoid some idiosyncratic responsibility he resents only then to become the object of resentment from the system he deals with. Often enough, he then drinks more to fight the system that resents him drinking and a vicious cycle is set up.

Avoiding Responsibility

While it is probable that Talbott and Gander refer in their term "disease" only to the organic consequences of excessive alcohol ingestion, and it is hoped this is the case, all too often the use of "disease" as applied to alcoholism is used as a means of providing the alcoholic individual and his family with an institutionalized method of avoiding their responsibility in producing the situation. This provides a positive valency attitudinally for alcoholism and potentiates the development of further drinking. Thus, the insistence that we view alcoholism as a "disease," while, granted, well meant, actually may increase the use of alcohol by the individual or society.

That guilt plays a large role in the alcoholic's life has been recognized for some time[11] and that alcoholics often play out some repetition compulsion of guilt, confession and forgiveness is a fact heavily utilized by, for example, those in Alcoholics Anonymous. The guilt that is being handled through this compulsion is unconscious but is often rationalized as "guilt concerning the excessive use of alcohol." Thus the mechanism serves to "bleed off" periodically excessive built up guilt (speaking rather metaphorically). Given that society, at least currently, does not assign guilt where there is no agreed responsibility for behavior, then if an individual is designated "irresponsible" for certain behaviors no guilt for it should follow. Thus we would expect that an alcoholic convinced that his behavior is the result of "disease" rather than intent would feel relief from guilt at least about his drinking.

This could conceivably result in one of two possible outcomes: one, that the unconscious guilt (or perhaps actual need to feel guilt) finding decreasing relief from the previously temporarily efficacious repetition compulsion causes the patient to experience a temporary increase of alcohol consumption before the behavior is extinguished; or two, that the patient, finding his old means of handling guilt threatened, leaves treatment. In the first case other means

of handling the guilt (or need for guilt) must be arranged (what we would term symptom substitution) and in the second case the treatment has been defeated. Obviously then, even if guilt is not the only factor involved in alcoholism, caution must be used in declaring the condition a "disease" and the individual not responsible for it.

Active Relatedness

It is hoped that the point is clear. While declaring alcoholism a "disease" may offer relief to some, and maybe even only temporarily at that, it is not a final answer. Those who insist that this is the case, while well meaning, may be causing more harm than good through their failure to consider the possible psychological consequences of doing so. To date the best management of the alcoholic remains with Alcoholics Anonymous where a concerted attempt is made to integrate the individual into a small society which permits active relatedness in many possible roles and provides the essential supports that such relatedness brings. To be sure, management often of necessity must include rigorous medical attention, but without a program of remedial socialization and often psychotherapeutic intervention that includes the family this attention and its benefits will be lost. We do not need to know that it is a "disease" to treat it.

In a recent article Bochoven and Solomon used the term "socially dependent population"[12] to characterize the population they considered. This consisted of patients who fit many different categories of diagnosis and possibly also alcoholics. They addressed themselves to management of these individuals without regard for the diagnostic label and offered some helpful suggestions. It might do well to consider the alcoholic the same way. Clearly the population of alcoholics is heterogeneous and any unitary understanding of the problem is lacking to create homogeneity of treatment that is specific. If we really want to do justice to our understanding of the problem, too early closure of our search for further possibilities can result in serious consequences. As our understanding of the social sciences increases it is becoming more evident that the quest for answers is never ending for as fast as we find answers society changes to demand new answers. ■

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Though efforts toward upgrading medical education in Vietnam were ended abruptly, the author is optimistic that the program was of lasting value.

Final Report on the AMA Vietnam Medical School Project

C. I. BRYANS, JR., M.D., *Augusta**

In December, 1968, Dr. William A. Scoggin, chairman of the Department of Obstetrics and Gynecology, Medical College of Georgia, visited Saigon at the invitation of the AMA and on August 1, 1969, signed a subcontract, assuming the responsibilities of Counterpart Department to that in Saigon. Since Dr. Scoggin was unable to return to Saigon because of illness, I became coordinator of the project.

For most of the time, we had two long term faculty members in Saigon; Dr. Gerald I. Wasserwald from August 5, 1969 to July 2, 1974; Dr. Benedict B. Benigno, Jr. from August 5, 1969 to July 27, 1973 and Dr. Earle M. Marsh from June 9, 1973 to September 30, 1974. Dr. Virginia McNamara was there from November 12, 1974 to April 5, 1975 as consultant to the Department of Community Health as well as to the Department of Obstetrics and Gynecology.

We also sent out 15 short term consultants, all men of national prominence who contributed greatly to the program.

I made five visits, staying an average of six weeks each time.

Dr. Nguyen Van Hong, chairman, Saigon, visited the Medical College of Georgia twice during this period, in March, 1970 and December, 1974. Dr. Nguyen Ngoc Giep, associate professor, visited us in May, 1973; Dr. Vu Tien Phuong, associate professor, in November, 1973; and Dr. Huynh Dien Qui, assistant professor, in December, 1974.

Dr. Nguyen Van Tu, professor of obstetrics and gynecology and associate dean of the Hue Medical School, was in Augusta from October 16, 1973 until November 11, 1973 as part of the administrative internship sponsored by the American Association of Colleges for Teacher Education.

Three graduates of our residency program received postgraduate training in this country under our auspices. Dr. Phung Thi Tho was a fellow in reproductive endocrinology at the Medical College of Georgia for three years. Dr. Huynh Dien Qui was a fellow in gynecological oncology at Emory University for one year and Dr. Tran Dinh Chuong attended the School of Public Health of the University of California and received the MPH degree in Maternal and Child Health.

Postgraduate Education

Our main effort in Saigon was in the area of postgraduate education as the need for teachers seemed to be of paramount importance. We were able to set up a three year American type residency program comparable in many ways to those in this country. We were able to graduate four classes, eleven people in all, from this program and have them certified as specialists in obstetrics and gynecology in Vietnam. Approximately 30 more received partial training.

Our long term faculty and consultants made daily teaching rounds at Tu Du Maternity and Nguyen Van Hoc-Gia Dinh Medical Center, worked in the operating and delivery rooms in both hospitals, gave lectures and conducted conferences for residents and faculty. Journal clubs were held monthly and there were periodic seminars in which a given subject was discussed in depth. All of this, of course, was in cooperation with the Vietnamese faculty.

Several of our consultants visited the medical school at Hue and the medical centers at Da Nang, Can Tho and Long Xuyen and numerous provincial and local hospitals and midwife stations. We also served as consultants to other hospitals in Saigon including Cong Hoa Army Hospital.

We were also invited to participate as guest speakers at meetings of the Vietnamese Medical Association and the Obstetrical and Gynecological Society of South Vietnam.

Our contact with medical students was primarily when they rotated through our service in the two hospitals. We also gave lectures to them periodically

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and Dr. Marsh presented a series of lectures on psychosomatic medicine and another on basic gynecology.

We were very fortunate in our faculty. Dr. Wasserwald was a young man of great drive and ambition with real administrative ability as well as being an excellent clinician and teacher. He, together with Professor Hong, was largely responsible for the early success of our program.

Dr. Benigno, another young man, was fully trained and certified in obstetrics and gynecology and had in addition a year's specialized training in gynecological oncology. He also was a fine clinician and talented teacher. He left in the summer of 1973 for further training in oncology at the M. D. Anderson Hospital in Houston.

He was succeeded by Earle Marsh of San Francisco. Dr. Marsh was trained in psychiatry as well as obstetrics and gynecology and was on the clinical faculty of the University of California. His years of experience in gynecology and psychiatry proved invaluable in Saigon. Dr. Marsh was extremely popular with the Vietnamese—faculty, residents and students alike.

Dr. Frederick M. Zerzavy of USAID-Public Health was of great help to the teaching program when he was in Saigon.

Community Medicine

In the last year of our program, we moved further into the field of community medicine in the area of maternal and child health. Dr. Virginia McNamara of our department has a MPH degree from Harvard and much experience in this field. She had had a previous short term visit in Saigon and returned in the fall of 1974 to help coordinate this program as consultant to the Departments of Community Medicine and Obstetrics and Gynecology. She worked primarily in the District 5 Clinic and the Minh Mang Dispensory in conjunction with the Under Six Program setting up prenatal and gyn clinics and teaching residents, students and midwives. In spite of many obstacles, she was having great success when the program ended. She left Saigon on April 4, 1975 because of the worsening political situation.

I cannot give enough credit and praise to Dr. Nguyen Van Hong, Professor and Chairman of the Department of Obstetrics and Gynecology of the University of Saigon. Professor Hong is a man of great wisdom, charm and clinical ability. He was entirely in accord with the program and worked hard and long for its success and was able to obtain the cooperation of his whole faculty.

Another point of strength was Dr. Nguyen Ngoc Giep, associate professor and chief of service at Nguyen Van Hoc Hospital. He is young, ambitious, American trained and an extremely capable clinician and teacher. He was also enthusiastic about our program.

This time last year I was very pleased with the progress we had made and although I of course was aware of the uncertain political situation, I was optimistic about the future and was anxious to continue and expand the program. We had been able to train a number of specialists and potential teachers of obstetrics and gynecology, had helped in the upgrading of the medical school and had begun to move into the field of community medicine and maternal and child health care. Most of the Vietnamese with whom I had contact with seemed to be enthusiastic and grateful. Our department received six decorations from the Vietnamese government. Drs. Wasserwald and Benigno were awarded the Education Medal, Second Class, Dr. Scoggin and I were awarded the Education Medal, First Class and Dr. McNamara and I each received the Gold Health Medal.

Of course, the whole situation changed very abruptly in the spring of 1975 and I have no idea whether we have left very much of lasting value behind especially since many of the best of our colleagues and trainees are now in the states. I can only hope that we made enough of an impression on those who were left behind that they can some day rebuild on the ashes of our endeavors.

Most of the faculty of obstetrics and gynecology left Saigon in the last days as did a number of the residents and students. We have been able to find jobs in this area for Drs. Hong, Giep, Chuong and Tho. Dr. Qui is in group practice in West Virginia but plans to return to Georgia after he passes the FLEX. Dr. Nguyen Bich Tuyet also plans to come to Georgia eventually. She is now living with her sister in Washington, D.C., studying for the ECFMG and FLEX. We hope to accept one of our former residents, Dr. Dang Phuong Thao into our program here in the summer of 1976 and probably others at a later date.

Apart from what we were able to do for the Vietnamese and the practice of medicine in Vietnam, I feel that this experience has been very profitable for the Medical College of Georgia. Certainly everyone who went out gained a great deal, both professionally and personally and the Medical College is now well known in all of Southeast Asia and has greatly increased its prestige in the United States as well.

Perhaps some day the political situation will change so that some of these fine people can return home and maybe there may even be another Vietnam Medical School Program. I would be more than happy to participate. ■

Delegates Report on the AMA Convention

Ed. note: We have asked several of MAG's delegates to the AMA Annual Convention June 26 through July 1 in Dallas, Texas to report on the activities of the reference committees they observed. Their reports follow. For detailed information on the convention proceedings, see AMA publications for July and August, specifically, American Medical News, *dated July 5/12, 1976.*

Reference Committee A

Earnest C. Atkins, M.D.

Many resolutions were considered by this committee. A few of these resolutions are reported as they were passed by the House of Delegates.

Resolution 135: Assurance of Professional Competence—"Resolved, that the AMA urge all peer review committees to make every effort to correct or to refer to the appropriate disciplining bodies, any physicians who do not meet accepted standards of professional conduct, including ethical behavior, or of professional performance." Passed as amended above.

Resolution 17: Fee Discrimination. This was a MAG resolution and was defeated. This resolution urged fee equalization for rural practitioners. William F. Dowda, M.D., MAG delegate, spoke and urged its passage.

The House amended the motion to read: (1) "That the AMA continue to emphasize usual and customary or reasonable charges as the basis for physician payment; (2) that physicians, especially those who are underpaid, should bill their appropriate fees for service, even if payors reduce the amount of payment; and (3) that the AMA redouble its efforts to seek amendment of the Medicare law as it pertains to reimbursement for physicians' services and recession of the economic index regulations, using all available legal means."

The House also voted (Resolution 78) to oppose the reduction of CHAMPUS fees. The House further passed various motions on the confidentiality of medical records and release of medical information.

Georgia Resolution 14: Cost Accountability. Harrison Rogers, M.D., MAG delegate, spoke to the Reference Committee and the House on this resolution. He was very persuasive, but the House referred it to the Board of Directors for study and report back at the 1976 Clinical Convention.

Reference Committee D

Charles D. Hollis, Jr., M.D.

Reference Committee D primarily considered matters concerning the Joint Committee for Accreditation of Hospitals requirements, audit requirements and other review procedures.

The Georgia delegation to the AMA was asked to question representatives from both the JCAH and the AMA Board of Trustees regarding the procedures by which JCAH establishes policy and the extent of AMA input in formulating guidelines for accreditation. It was pointed out that the AMA and the JCAH Board of Commissioners are attempting to provide better liaison between the organizations.

The JCAH Board of Commissioners is composed of 20 members. Seven of these are nominated by the AMA, two of whom are members of the Board of Trustees, three are nominated by the American College of Physicians, and three by the American College of Surgeons. The remaining seven are nominated by the American Hospital Association. In addition, when matters of policy or formulation of new guidelines are being discussed, the vice-president of the AMA sits in as an ex-officio member. The resulting answer to the question from Georgia was that there is sufficient opportunity for input from the AMA and other medical organizations in the decision-making process by the JCAH, but the JCAH is an autonomous body and does not always follow the opinions offered by any one of the participating medical groups.

Current Policy

Some delegates questioned whether or not the physician surveyors sent out by the JCAH always followed the most recent policies and guidelines of the Board of Commissioners in judging individual hospitals. John D. Porterfield, M.D., president of the JCAH board, admitted that there are problems at times in obtaining cooperation from individual surveyors toward implementing current JCAH policy. He pointed out that any hospital group which has doubts about requirements as stated by an individual

site surveyor should ask for written documentation of these requirements, and, if necessary, appeal directly to the JCAH office. Dr. Porterfield stated that the governing board is acutely aware of the problem and is making an effort to improve the situation, but that only time will make it possible to eliminate all inconsistencies created by individual surveyors.

Complaints were made that there is no one single source for determining current requirements by JCAH for accreditation. Dr. Porterfield admitted that the basic manual had been modified from time to time and that current policies frequently were included in multiple supplements to the basic manual. He admitted that this makes it very difficult for an individual institution to determine what actually is required of it in any particular year. A strong appeal was made by the Reference Committee to have the JCAH develop a current manual of requirements which could serve as a single source of information for institutions studying JCAH policy.

Much discussion had taken place in previous sessions of the House of Delegates regarding the JCAH requirement for listing in minute detail delineation of privileges for staff membership on hospital medical staffs. Many forms had been made available to the hospitals indicating that these met the JCAH requirement of a "laundry list" in delineation of privileges. Dr. Porterfield and the Board of Trustees who are members of the JCAH Board of Commissioners stated emphatically that the JCAH does not require this detailed delineation of privileges. All that is required is a general statement as to the type of privileges being requested by a physician, consistent with his training and board qualifications. It was pointed out in the discussion that such detailed listing of privileges is not only burdensome, but that it might create legal problems, in that if a particular procedure was not listed in the request for privileges inadvertently, it might be stated in court that such privileges had not been granted to the physician. The JCAH and members of the Board of Trustees urged that all hospitals cease making detailed listing of privileges as part of their process of credentialing.

There had been proposed a requirement for 24-hour admission review under PSRO and perhaps supported by the JCAH. At the Reference Committee discussion, it was pointed out by Dr. Allen Nelson, a member of the national PSRO board, that more feasibility has been allowed in admission review procedures and that at least 72 hours will be allowed. Under circumstances where hospital review procedures are working well, it might not even be necessary to have a rigid time set for admission review. The JCAH representatives stated that they also do not have any rigid time requirements for these review procedures.

Some states have allowed podiatrists to become members of hospital staffs. A letter of resolution was introduced to ask the JCAH to avoid establishing any policy about allowing staff membership to any specifically identified allied health professionals. The JCAH representatives said that in the past they actually had stated that the granting of staff membership to a podiatrist would be grounds for refusing accreditation. At this point, they have not reaffirmed the policy of refusing accreditation to hospitals with podiatrist staff members, but really have not faced the formulation of new policy in this regard.

At present, it seems that each individual hospital staff will have to decide about the offering of hospital privileges to podiatrists, but all hospital staffs are strongly urged to limit the privileges to specified procedures without allowing full staff membership to the podiatrists. If the podiatrist has privileges without membership, the physician responsible for the history and physical thus becomes responsible. He is able to and required to supervise the work of these allied professionals. In summary, both the AMA and the JCAH strongly urge hospitals to avoid the pitfall of allowing membership on the staff for podiatrists or any other specifically identified allied health professionals, but that the permission to perform certain procedures under supervision would have be decided individually by each hospital staff.

The AMA, through its Board of Trustees, requested that policies regarding review procedures under PSRO, the JCAH, Medicare, Medicaid, and any other groups requiring review procedures, allow standardization of their review processes. The AMA has under study a project to offer to all of these groups a standard for establishing medical audit. It was strongly urged that such a standard be accepted to avoid unnecessary duplication of certain review procedures. It also would avoid the problem of establishing double standards in certain situations.

In certain areas, insurance companies are requesting the release of audit reports from hospitals. There also have been occasions when requests for reports have come from members of a hospital authority. It was stated emphatically that reports of audit processes should be kept as confidential information. Release of audit reports should not be made to insurance companies, hospital authorities or any other group except those individuals and committees authorized to work with the audit process.

Again discussion arose regarding the difference in responsibility for medical audit of quality care versus utilization review for cost control purposes. It was restated that the AMA position that medical audit is a responsibility of the physician and should be done as a part of his responsibility to the institution and the patient without charge. On the other hand,

utilization review is required by third party carriers for cost control purposes and does not involve assessment of quality. For this reason, it is reasonable to expect compensation for time spent in utilization review for third party carriers.

The Department of HEW requires that all patients in nursing homes be visited by a physician at least every 60 days and many states require that the patient be visited by a physician every 30 days. There was considerable discussion about the need for examination of patients in nursing homes at regularly prescribed intervals. There was some feeling that if the patient is in a nursing home, he should be checked occasionally, not only to assess current conditions, but also to determine whether or not he still requires nursing home care. The general consensus, however, was that it would be better to leave to the judgement of the physician the need for examinations of nursing home patients and that a specific time interval not be set by either the state or by HEW.

Problems of periodic evaluation of the physical and mental state of the physician members of the hospital staffs were discussed. At times, a physician with deteriorating health can prove a problem to hospitals and to the patient. It was concluded, however, by the group discussing the matter, that each hospital should establish its own mechanism for handling this matter. It suggested that a good way would be for the credentials committee simply to require that physicians regularly present evidence of their physical and mental status qualifying them for the work they are supposed to do in the institution.

The discussion revealed that there was considerable dissatisfaction with the operation of the JCAH accreditation process and that the JCAH generally is aware of the dissatisfaction and in many instances is aware of the problem. It also became clear that many members of the House of Delegates were not well informed about the way in which the members of the JCAH Board of Commissioners were chosen or about the role the AMA, the ACP and the ACS played in the JCAH policy-making activities. The rather extensive discussions were in general a healthy airing of the problems as seen by physicians in meeting JCAH requirements. Representatives from the JCAH also seemed receptive to suggestions and appeared amendable to suggestions about improvements and about improved liaison with those who represent the practicing physician.

Reference Committee G

Robert E. Perry, M.D., Brunswick

The main subjects discussed by this Reference Committee concerned the Georgia resolution on a membership opinion poll on national health insurance, as well as related resolutions from the Louisiana delegation and Dr. Frank A. Rogers, delegate from California.

After much discussion at the Reference Committee hearing, the Committee recommended that the special committee of the House of Delegates on Membership Polls be re-activated and that approved techniques for polling the membership be developed. A progress report is to be submitted to the House of Delegates at the 1976 Clinical Convention. The Georgia delegation felt that the resolution as introduced by our delegates should be brought to the floor of the House. Valiant attempts were made by the Georgia delegates, using all known parliamentary procedure, to have the resolves of the Georgia delegation's resolution substituted for those of the Reference Committee. In spite of these many efforts, however, we were unsuccessful.

The remainder of the actions of Reference Committee G were concurred with by the Georgia delegates and were not of a controversial nature. The Reference Committee did recommend that a resolution calling for the establishment of a physician's master file not be adopted. This master file would include information from state licensing boards, disciplinary actions of hospitals and medical societies against physicians, with the purpose of providing this information to inquiring constituents for use in determining privileges and validity of licenses. ■

Claims Received and Processed by St. Paul Against MAG Members

WILLIAM W. MOORE, JR., M.D., *Atlanta*
Chairman, Professional Liability Insurance Committee

The following is a breakdown of claims, or suits, against Georgia physicians which were open as of December 31, 1975, or had been closed out during 1975. These claims, all 868 of them, are broken down as to classification and county.

At the MAG Annual Session in April, due to a computer error, Decatur County was credited with 28 claims that properly belonged to DeKalb County. We regret this error and are happy to correct it.

Frequency by County (Base: 868 claims)

County	*Number*
Fulton	290
DeKalb	66
Cobb	51
Bibb	32
Richmond	30
Chatham	29
Clayton	21
Muscogee	15
Glynn	13
Hall	12
Whitfield	12
Ware	11
Dougherty	10
Remaining Counties (Fewer than 10 each)	274

Class 1

Leading Claim Allegations (Base: 138 claims)

Allegation	*Number*
Improper Treatment: Drug Side Effect	13
Failure to Diagnose: Infection	11
Improper Treatment: Lack of Supervision, Control	11
Failure to Diagnose: Cancer	7
Failure to Diagnose: Abdominal Problem (Other)	5
Abandonment	5

Frequency by County

County	*Number*
Fulton	54
Cobb	10
DeKalb	9
Richmond	6
Bibb	4
Ware	3
Whitfield	3
Remaining 19 Counties (Fewer than 3 each)	49

Class 2

Leading Claim Allegations (Base: 139 claims)

Allegation	*Number*
Failure to Diagnose: Fracture or Dislocation	15
Improper Treatment: Fracture or Dislocation	11
Failure to Diagnose: Implanted Foreign Body	9
Abandonment	8
Improper Treatment: Birth Related Problems	7

Frequency by County

County	*Number*
Fulton	18
DeKalb	17
Bibb	5
Chatham	5
Clayton	4
Hall	4
Remaining 50 Counties (Fewer than 4 each)	86

Class 3

Leading Claim Allegations (Base: 99 claims)

Allegation	*Number*
Improper Treatment: Surgical Error	19
Improper Treatment: Surgical Improper Procedure	8
Improper Treatment: Fracture or Dislocation	6
Improper Treatment: Birth Related Problems	4
Improper Treatment: Drug Side Effect	4

Frequency by County

County	*Number*
Fulton	23
Richmond	8
Chatham	4
Bibb	3
DeKalb	3
Floyd	3
Hall	3
Muscogee	3
Whitfield	3
16 Remaining Counties	46

Class 4

Leading Claim Allegations (Base: 201 claims)

Allegation	*Number*
Improper Treatment: Surgical Error	36
Improper Treatment: Surgical Improper Procedure	12
Improper Treatment: Surgical Postoperative	11
Improper Treatment: Medical Equipment	9
Failure to Diagnose: Cancer	5
Improper Treatment: Drug Side Effect	5
Improper Treatment: Surgical Sponge Left	5

Frequency by County

County	*Number*
Fulton	82
Cobb	12
Clayton	11
Chatham	6
DeKalb	6
Glynn	5
Remaining Counties (Fewer than 4 each)	79

Class 5

Leading Claim Allegations (Base: 291 claims)

Allegation	*Number*
Improper Treatment: Surgical Error	54
Improper Treatment: Fracture or Dislocation	31
Improper Treatment: Birth Related Problems	23
Anesthesia: Cardiac Arrest	12
Anesthesia: Teeth Damage	11
Failure to Diagnose: Infection	9
Improper Treatment: Lack of Supervision, Control	9
Improper Treatment: Surgical Sponge Left	9

Frequency by County

County	*Number*
Fulton	113
Cobb	24
DeKalb	23
Bibb	16
Chatham	13
Richmond	10
Muscogee	5
Remaining Counties (Not over 4 each)	87

Seminar Helps Physicians Deal With Emergency Situations

A three day seminar on "Management of Emergencies," from snakebite and near drowning to acute myocardial infarction, was held for physicians, nurses and emergency medical technicians June 14-16, 1976 at the DeSoto Hilton Hotel in Savannah. The program was sponsored by the Medical Association of Georgia and the Memorial Medical Center in Savannah.

The program was designed to be of critical interest to primary physicians who might be confronted with emergency situations in and outside the hospital. Some 55 M.D.s attended, along with 64 emergency medical technicians, registered nurses and licensed practical nurses.

One of the highlights of the seminar was a Georgia Heart Association conducted practical course on basic life support. Physicians practiced cardiopulmonary resuscitation on the "Recording Annie" mannequin, and some 15 attendees were issued the GHA certificate for completion of this course.

Out of state speakers included Brooks F. Bock, M.D. and Ronald L. Krome, M.D., associate professors of surgery at Wayne State University in Michigan who discussed emergency management of trauma. Dr. Krome is president-elect of the American College of Emergency Physicians. Reviewing the legal aspects of emergency treatment was Neil Chayett, a Boston lawyer and lecturer for Boston University and Tufts University.

Program co-chairmen were Selwyn T. Hartley of Atlanta and Lester M. Haddad of Savannah. Chairman of the Committee on Emergency Medical Services, which coordinated the meeting, is Carl Jelenko, III, of Augusta. The seminar was approved for 20 Category I hours by the American Medical Association and American College of Emergency Physicians, and 20 prescribed hours from the American Academy of Family Physicians.



Program Co-Chairman Lester Haddad (L) reviews the seminar schedule with speakers Ronald S. Krome and Brooks F. Bock, associate professors at Wayne State University in Michigan. Dr. Krome is president-elect of the American Academy of Family Physicians.



Ollie O. McGahee of Jesup (R) instructs a conference participant in cardiopulmonary resuscitation using a mannequin which records the success of his efforts. Dr. McGahee is part of the Georgia Heart Association's advanced cardiac life support faculty.

editorials
editorials
editorials

GaMPAC: A Way to Get Involved

AS I BECOME INCREASINGLY involved each year in the political arena it is frustrating to me to see the tremendous number of physicians and their families who regard political affairs as a haphazard adventure that takes place every two years. Yet, I am encouraged to find the increasing number of physicians and their families who want to become knowledgeable and active in the political process.

When we realize that it was not until 1962 that GaMPAC and AMPAC were organized, it is readily apparent that physicians got a late start in their efforts to influence the election of specific candidates. But GaMPAC each year is becoming more effective as the voice of organized medicine. As the membership of GaMPAC increases, the activities of political action will increase.

The Board of Directors of GaMPAC is composed of a physician from each congressional district, two members at large and officers. Each district also is represented by a member of the Auxiliary. These members are presented to the Council of MAG for approval or rejection. It is the responsibility of this GaMPAC Board to support candidates after an appropriate selection process has been conducted. It may or may not be apparent to you why a candidate was chosen for support, but these officers, Board members and our staff are available to discuss these selections with you. Yes, we have made some errors in judgment. Yes, we are critical of ourselves. And self-criticism brings corrections. These corrections keep us moving toward ever higher standards.

Excellent Opportunities

Our involvement in candidate support is on both the state and national level. This year we find that 52 (including three in Georgia) U.S. House of Representative and eight U.S. Senate seats have no incumbent running. This offers the state PACs across our nation an unprecedented opportunity to work with candidates for these offices. We also have found many of our state legislative friends have tough campaigns in their districts and we must actively support these people. Your membership in GaMPAC enables your Board to give financial support to these candidates. You also must physically support these friends to enable your Legislative Committee to effectively voice your wishes in passing legislation in Georgia and in our nation's capital.

We hope your GaMPAC Board has made progress each year in its effort to more effectively communicate with its membership. We hope you feel that the GaMPAC Brunch is the highlight of the MAG Annual Session and that we can continue this social and informational function. You must make your wishes known to GaMPAC. We can function as you desire only if we know your thoughts and opinions.

In closing, I would like to quote the last few lines of a poem written by Rex E. Kenyon, M.D. of Oklahoma City, Oklahoma, a member of the AMPAC

Board of Directors. The poem is titled, "Bicentennial Means This To Me . . ." and the author is answering his own question: "How can I help to preserve my heritage?"

By taking part in political scenes . . .
For Congress needs GOOD men . . . just like the Marines.
'Cause our heritage, then . . . if it is to last
May all well depend on the laws that are passed.
So I'll study candidates, then make my choice,
Lending my money, my effort, my voice.
I'll call on the telephone, drop folks a note,
Then in November, I'll get out the vote.
Perhaps there's another good way to defend
But our future relies upon laws made by men.
Our grandchildren's heritage is not guaranteed
For the blessings of freedom are fragile indeed!

J. Dan Bateman, M.D.
Chairman, GaMPAC
410-12 Fourth Avenue
Albany, Georgia 31705

MEDICAL EXAMINERS BOARD REVIEWS COMPLAINTS, ADMINISTERS FLEX EXAM IN JUNE

The June 14-16 meeting of the Composite State Board of Medical Examiners was held at the Board office in conjunction with the FLEX examination which was administered to nearly 300 candidates in Atlanta and Augusta. To date the Board had met 11 days in 1976, exclusive of special committee assignments.

Officers for 1976-1977 were elected: James C. Dudley, M.D. of Americus, president and Alfred Haight, D.O. of Tucker as vice president. Current members reappointed by Gov. Busbee and sworn into office include Albert M. Deal, M.D. of Statesboro; Robert E. Thompson, M.D., of Toccoa; and Hassie Trimble, D.O. of Moultrie. J. Watts Lipscomb, M.D. of Morrow was a new appointee.

Among the routine matters handled by the Board at this meeting were an interview and approval for a provisional license; interviews and certification for four physician assistants who appeared with their sponsoring physicians; review and approval of four requests for duplicate licenses; final certification of five licensees who had completed internship; and renewal of one institutional permit.

All but 13 of 95 requests for licenses by reciprocity were approved. The rest were reviewed individually by the Board and half were denied licensure.

A great percentage of time was devoted to complaints against physicians and PAs for possible or obvious violations of the Medical Practice Act and evaluating potential or current licensees who have had charges brought against them in other states. Sixty-five such cases were reviewed and in seven cases intensive investigations and full Board legal proceedings, if justified, were authorized.

During the last session of the General Assembly, the certification of orthotists (those trained to fit braces and appliances) was brought under the Medical Practice Act. A committee of the Board had met with representatives of the Georgia Orthotists Association and made recommendations as to rules, certifying examinations and fees, all of which were approved.

president's letter

'Under his own tree, in peace and safety'



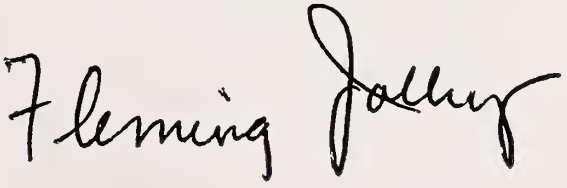
THOSE EIGHT WORDS have been around for a long time. I believe they express a desire for many of us individually as well as in organized medicine. This seemed apparent in many considerations in the annual session of AMA in Dallas.

A young Minnesota medical student expressed this thought before a reference committee. "I was brought up with the following priorities and feel they are still important—God, first; country, second; family, third; work, fourth."

On a different note, the auxiliary to the student medical association has been discontinued. It seems that a year or so ago, the officers of this organization had divorced their student husbands. The president of the student association was visibly concerned by this increasing problem. Little peace under some trees.

As the summer continues, the need to draw apart from the rigors of the medical practice and find rest, refreshment, reassurance and a renewal in our commitments is important.

Hope the summer is kind to each of you. Some of the thoughts above are taken from the "Forward, Day by Day."



Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Mammography and Radiation Dose

ROBERT L. EGAN, M.D., *Atlanta**

FOR OVER 20 YEARS we have been relentlessly studying the radiation dose radiographic quality ratio in mammography. These correlations have been investigated relating to numerous parameters that included constantly emerging types of equipment, types of receptors, x-ray tubes, combination of filters and collimators to improve the detection of earlier breast cancers. At one point our three physicists spent an entire five year period investigating the previously unexplored mammography kilovoltage range.

These efforts culminated in many straightforward conclusions that should be impressed on all physicians: most importantly radiographic quality need not be sacrificed for radiation dose. Yet carefully gathered information disseminated into an arena already clouded with poorly investigated claims is not always accepted.

Too many women's lives are being jeopardized by claims that mammography causes more cancer than it detects based on the most fragmentary, and most likely the least pertinent, bits of information. Extrapolation in a straightline method of whole body or torso high dose-high energy radiation to the small volumes of externally placed breasts studied by low energy x-rays is not an adequate, or logical, exercise to reach any conclusion.

Both delays on the part of the patient to investigate breast changes and poor quality mammography used by radiologists to avert possible criticism of radiation detract markedly from good patient care. Any radiologist pressured into inferior quality studies for any reason invites much more serious criticism. Physicians should view with reservations the predictions of a few, who are neither bona fide radiologists, oncologists, or epidemiologists, of the dire effects of mammography. Radiologists do not need such tactices aimed at the general public to be reminded it is their duty to carry out radiographic examinations of quality with the least amount of radiation possible.

During the past two years the physical aspects of mammography are being investigated by a commissioned group of physicists at six centers in the United States with consultation from the American Association of Physicists in Medicine with approval of the American College of Radiology Committee on Mammography and Diseases of the Breast and supported by the National Cancer Institute. This program came about as a part of a systematic inquiry as to the value of mammography in detecting early breast cancer by the Americn Cancer Society and the National Cancer Institute in their breast cancer screening demonstration projects. All equipment has been intercompared and calibrated against the National Bureau of Standards. Continuous monitoring of the various centers established sound reproducible data. Data on various mammography units and associated dosages have been well categorized for inspection. The 1976 evaluation of the 63 systems used in the 29 sereening centers indicated an average dose to the skin of 2.2 rads per exposure.

The carcinogenic skin dose of x-ray is known to be extremely high when compared to the doses employed in routine diagnostic x-ray procedures. There is no

* Chief, Mammography Section, Emory University, Atlanta, Ga. 30322. Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

known carcinogenic x-ray dose of fibroglandular tissue of the breast; such a dose perhaps would even be higher than the carcinogenic skin dose since these tissues are largely protected from trauma, surface irritants and actinic rays. Also, during mammography with this low kilovoltage, with a half-value layer of 1.25 cm of tissue, the fibroglandular tissue receives only a small fraction of the skin dose.

With high resolution mammography in 2,000 asymptomatic women, over 35 years of age, in the ACS-NCI breast screening program at Emory, 19 cancers were demonstrated; only one was palpable after localization by mammography, the only one with an axillary lymph node metastasis. Each study required an average of less than 1.5 rads to the fibroglandular tissue of the breasts. It is difficult to conceive of dissemination of unfounded adverse criticism of such a life saving, and reasonably inexpensive, procedure—certainly inconceivable to these 19 women. This program indicates high quality mammography need not and cannot be safely compromised.

The American College of Radiology, a knowledgable body both in diagnostic and therapeutic radiology, whose membership includes some of the world's most renowned biophysicists endorses these screening programs. Although not as accurate as in postmenopausal fatty breasts, mammography is most useful in the 35 to 50 year age group in whom the greastest number of cancers occur in breasts most difficult to evaluate clinically. This valuable complement to breast evaluation is not to be denied younger symptomatic women or young asymptomatic women as a baseline study.

There continues an obligatory challenge to the medical profession to make highly productive mammography available to the female population. This can be accomplished through efforts of the team of informed physician, the already concerned patient and the conscientous radiologist to produce high quality mammograms without undue radiation. ■

NOVEMBER SYMPOSIUM COVERS CURRENT CONCEPTS IN IMMUNOTHERAPY

The Second Annual Interdisciplinary Symposium on Cancer-Related Problems will be presented by Robert Winship Memorial Clinic and The Emory University School of Medicine, Friday, November 5 and Saturday, November 6, 1976 in the new Woodruff Medical Center Administration Building on Emory University Campus.

This two-day conference will be devoted to 1) the review of fundamentals of tumor immunology; 2) the effects of conventional modalities of treatment on the immune system; 3) the immunotherapeutic approaches to malignant disease; and 4) the application of immunological principles to specific cancers.

The highlight of the two-day conference will be the first J. Elliott Scarborough Memorial Lecture presented by Donald L. Morton, M.D., professor of surgery, chief, Division of Oncology, University of California at Los Angeles School of Medicine. Dr. Morton will talk on "Surgery as Immunotherapy."

Other outstanding speakers will include Alan C. Aisenberg, M.D., associate professor of medicine, Massachusetts General Hospital, Harvard Medical School, Boston; Paul L. Chretein, M.D., director, Tumor Immunology Laboratory, Department of Surgery, National Cancer Institute, Bethesda, Md.; Loren J. Humphrey, M.D., professor and chairman, Department of Surgery, University of Kansas Medical Center, Kansas City, Kan.; and Joseph G. Sinkovics, M.D., professor of medicine, University of Texas System Cancer Center, M. D. Anderson Hospital and Tumor Institute, Houston.

Members of the faculty at Emory University School of Medicine who will be participating include Evan L. Frederickson, M.D.; John R. McLaren, M.D.; William C. Cassel, Ph.D.; Daniel W. Nixon, M.D.; Melvin R. Moore, M.D.; Z. L. Olkowski, M.D.; Douglas R. Murray, M.D.; W. Ralph Vogler, M.D.; Robert L. Brown, M.D.; and Sam A. Wilkins, Jr., M.D.

The registration fee for this two-day symposium is $75 and will include refreshments during the sessions, luncheon on the first day and a buffet dinner that evening at the Druid Hills Golf Club. A cash bar will be available.

Approximately eight hours of credit for continuing medical education will be given as well as a certificate for attendance.

Tickets to the Tech-Notre Dame football game on Saturday, November 6, are being made available to those who respond immediately by sending a check for $7.50 per person, made payable to Dr. Douglas R. Murray, Chairman of the Symposium, Emory University Clinic, Atlanta, Georgia 30322.

Formal registration announcements will be forthcoming in the near future.

heart page
heart page
heart page

High Blood Pressure Education in Schools

JACK E. BIRGE, M.D., *Carrollton**

PERHAPS SOME OF YOU are aware of Georgia Heart Association's efforts in introducing an educational curriculum on high blood pressure in our school systems. It is a project worth consideration by all physicians in the State of Georgia since it is a unique effort that has proven effective in health education of the public.

The recognition that high blood pressure is a serious health hazard contributing to the development of heart disease, vascular brain disease, and kidney disease; and the fact that an estimated 23 million Americans have high blood pressure presented an urgent necessity to educate the general public regarding the dangers of high blood pressure.

Other serious diseases affecting large numbers of people have brought forth public educational efforts in the past. Many of these efforts have been disappointing when looked at from the standpoint of lasting beneficial effects. Review of the current methods utilized in educating the public in health matters brought our Georgia Heart Association committee to the conclusion that for any educational program to be effective it must be a continuing program conducted from year to year. It was also concluded that for every community to become involved required utilizing resources present in all communities. The school systems, of course, fit this bill.

The Committee On High Blood Pressure Education In The Schools was established by the Georgia Heart Association. Out of this committee, composed of doctors, nurses, educational administrators, and teachers, came the schools curriculum and program with the basic goal to truly educate our school children regarding high blood pressure, including the necessary anatomic and physiologic background to understand what was being taught, and through the children to educate their parents and the public. The doctors in each community would be involved but in a way so as to require only a very small amount of their time. A single physician in each community would be asked to give one PTA program on high blood pressure and introduce the program to the parents attending, thereby providing support from the local medical community.

The program is simply this. A five day curriculum on high blood pressure was developed involving classroom instruction on the basic facts of the cardiovascular system and high blood pressure followed by instruction and actual practice in the taking of the blood pressure. Each student was allowed to take the blood pressure cuff and stethescope home along with printed matter regarding high blood pressure to be presented to their parents. They took blood pressures of their parents and anyone else they so desired in the home. Some took blood pressures of the entire

* Dr. Birge is a family physician who serves as chairman of the Georgia Heart Association's Schools Task Force. He is in practice at The Carrollton Clinic, Carrollton, Ga. 30117.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

neighborhood. These blood pressures were recorded by the students and brought back to the teacher who in turn passed the data on to the local county heart unit for professional review. The abnormal blood pressure measurements brought in by the students were checked by nurses and doctors in representative areas conducting the program and were found to average 85 percent accuracy. This prompted local heart units of the Georgia Heart Association, which aided in conducting this program, to suggest follow-up to all individuals, who for any reason might suspect that they have an abnormal blood pressure, whether by the students' blood pressure measurement or by a strong family history of high blood pressure. Of course, in most households the students attempted to teach the adults how to use the sphygmomanometer and the stethescope.

An important fact about the program is that the teachers do all the teaching. The program is initiated into a school system by the Schools Commitee of Georgia Heart Association which holds a teaching seminar for the science teachers. The science teachers in turn instruct the students as well as other science teachers within the school system. These science teachers are called upon to instruct science teachers in neighboring school systems thereby providing additional spread of the program. The curriculum has also been introduced in several of the colleges and universities teaching future teachers as a part of their preparation. The curriculum is taught every year.

Potential for Reaching Many

As evidenced by this brief outline of the schools program a small number of health professionals, instructing teachers, ultimately reach a large number of the population. The curriculum on high blood pressure has now been taught to 20,000 children who have taken some 100,000 blood pressures, and this will continue to grow in number every year. Another interesting point is the involvement of the parents of these children, many of whom are young adults conspicuously absent from most of the mass screening programs to detect high blood pressure.

In spite of the possibility that some of the blood pressure measurements by the students are inaccurate, sufficient interest has been generated among adults to have their blood pressure checked by local health care facilities. Examination of the data provided by the students is quite interesting, however, and thus far seems to conform to incidence and distribution of hypertension in the adult population found in other reported large scale screening. It is believed that the incidence of uncontrolled high blood pressure is dropping in areas that have instituted the schools program.

The potential of this program as a source of data regarding blood pressure especially in children, an area still not well defined, is unprecedented. It is certainly feasible that proficiently trained science teachers could record the blood pressures of every child in their classes and even identify those children of hypertensive parents. Blood pressure measurements could be made more often than once a year on the same child and could be made from year to year throughout the child's school years, yielding data on a vast scale which could answer questions about the course of high blood pressure still not fully answered.

General Medical Knowledge Needed

Most physicians would agree that the public is generally medically illiterate. Instruction in the area of high blood pressure in our schools has brought forth the necessity of examining the entire area of health education indicating the need to provide teaching in all areas of common disease thus better preparing individuals to take care of themselves. An individual knowledgeable in the basics of the common disease may seek medical care earlier from vague prodromal symptoms of potentially serious diseases and may follow treatment instructions better by understanding more of why he is given certain instructions and specific medications.

The Schools Committee of the Georgia Heart Association is currently expanding

the curriculum development to cover other important areas of cardiovascular disease. This program will eventually involve grades one through 12 and will cover all major areas of heart disease.

The basic responsibility of educating the general public in health falls squarely on the shoulders of the medical profession; doctors, nurses, and the allied medical fields. It is extremely important that physicians in the private practice of medicine become involved. Just as it is the basic responsibility of the physicians of each community to insure that the best quality of medical care possible is provided in their community, so is it the responsibility to educate the people of each community regarding important health matters.

The schools program in high blood pressure education is one method of providing health education to each community. This program is spreading rapidly throughout the State of Georgia and has aroused considerable national interest in the program. Thus far Georgia Heart Association has received requests for program information and guidelines from 40 states in the USA and from several areas of Canada. The door to health education has been opened in our schools. Hopefully, similar efforts will follow in such areas as diabetes, cancer, infectious disease and others until a comprehensive curriculum on health is introduced in every school system. Then better health for all will be achieved. ■

HEART ASSOCIATION PRESENTS ADVANCED LIFE SUPPORT COURSE FOR PHYSICIANS

The Georgia Heart Association will present an Advanced Life Support (ALS) Instructor Course for Physicians Friday through Sunday, August 27-29 at Woodward Academy in College Park.

Robert F. Finegan, M.D., anesthesiologist and chief of staff at South Fulton Hospital and an American Heart Association affiliate faculty member in ALS, is director of the course.

This standard course was developed by the American Heart Association as directed by the National Academy of Sciences-National Research Council. It is designed for cardiologists, emergency room physicians, anesthesiologists and other physicians actively engaged in the area of advanced life support.

Participants in the course should have completed a basic life support course, preferably at the instructor level or above. Those who successfully complete the ALS course will be certified as ALS instructors.

"A realistic goal, for most hospitals in Georgia, would be to have at least two physicians trained as instructors in Advanced Life Support," Dr. Finegan said. "This course provides an opportunity for hospitals to realize this goal."

Course content includes adjunct to airway and breathing; surgical intervention for obstructed airway; suctioning devices; adjuncts to circulation; monitoring; intravenous techniques; essential drugs; and stabilization and transportation. Instruction will be by lectures and performance testing.

The Georgia Heart Association's CPR (Cardiopulmonary Resuscitation) Task Force is in charge of the course. Robert P. Cunningham, M.D., is chairman. For more information, contact the Heart Association at 2581 Piedmont Rd., N.E., Atlanta, GA 30324. Phone (404) 261-2260.

PA COMMITTEE INVITES TESTIMONY

MAG's Committee on Physician Assistants invites the testimony of any MAG member who is aware of an actual or potential problem related to the employment of PAs in Georgia. At the recommendation of the 1976 House of Delegates, the Committee will work this year at uncovering these problems and attempting to achieve workable solutions.

Testimony may be submitted in writing to the Chairman of the PA Committee (Jack Menendez, M.D.) at the MAG office or may be presented orally at a meeting of the Committee. The next meeting is scheduled for 3 p.m., Friday, October 15 at the MAG Headquarters Building in Atlanta. If you plan to testify at this meeting, please contact Stephen Daniel at (404) 876-7535.

Revision of Georgia's Adoption Laws

JAMES B. OUTMAN, *Atlanta**

THE 1976 GEORGIA GENERAL ASSEMBLY considered legislation[1] designed to revise and modernize Georgia's adoption statutes. The Bill, which represented the first attempt in 35 years to effectuate a comprehensive revision of Georgia's adoption statutes, was reported out of the House Judiciary Committee with a "do pass" recommendation but died in the House Rules Committee. The proposal will be resubmitted in January, 1977; this article will explain its principal features.

The proposal is the product of the Committee for Adoption Revision (CAR) and is a result of over two years' work by that Committee. CAR is a voluntary association of persons concerned about the adoption process and was organized through the efforts of Robert M. Flowers, M.D., with the support of the Georgia Chapter, American Academy of Pediatrics. Many problems and concepts were considered by CAR and significant input was received from the Maternal and Infant Health Committee.

Principal Features of Proposed Legislation

The proposed legislation is the product of a section-by-section review of Georgia's present adoption law (Code Chapter 74-4) which was enacted in 1941. The proposal seeks to revise and modernize Georgia's adoption law and does *not* change either the basic procedures or the types of adoptions which may be arranged in Georgia. An adoption may be either an agency adoption (through the Department of Human Resources or a licensed child-placing agency) or an independent adoption. In an agency adoption the child is first released to the agency and is then placed with the adopting parents. In an independent adoption the child is placed by the biological parents directly with the adopting parents or indirectly, through their agent, e.g., a doctor, lawyer or clergyman.

Three Types of Adoption

The proposed legislation would further divide independent adoptions so as to recognize three types of adoptions: (1) agency adoptions following either the biological parents' voluntary out-of-court surrender of the child or the judicial termination of parental rights; (2) independent adoptions other than by stepparents or relatives which could take place only after the biological parents' rights have been voluntarily surrendered in writing to the persons desiring to adopt the child, provided such persons file their petition for adoption within 60 days of the surrender; otherwise, the surrender operates in favor of the Department of Human Resources; and (3) stepparent and relative adoptions which would follow a voluntary out-of-court surrender.

Nonrelative independent adoptions represent a significant percentage of Georgia's adoptions and the proposed legislation is designed to provide greater safeguards to

* Prepared at the request of the Medical Association of Georgia. Mr. Outman is a partner in the firm of Nall, Miller & Cadenhead, 1500 Equitable Building, Atlanta, Ga. 30303, and is Vice-Chairman of the Committee for Adoption Revision.

all parties involved and is not designed to prevent such independent adoptions. Under the proposal the biological parents would continue to have the freedom to arrange for the adoption of their offspring either directly or through an agent and to voluntarily surrender their parental rights without a court appearance.

The proposal would add new sections to the law specifying the form of the written surrenders, both for agency and independent adoptions, so as to provide uniformity and minimize misunderstandings. In addition, the proposal contains a 10-day revocation right which would allow the biological parents to withdraw their surrender any time during the 10-day period following its execution. Present Georgia law does not allow the withdrawal of a surrender as a matter of right; however, such a provision should provide greater security for the child and the adopting parents once the 10-day period has passed. Consideration was given to the fact that most surrenders for independent adoptions are executed immediately following the birth of the child, many times while the biological mother is still hospitalized and possibly under the effects of medication. The 10-day period would allow the biological parents time to more fully appreciate the effect of their decisions. Though a revocation is not desirable, it is certainly less traumatic to all parties concerned if the placement is reversed within the first 10 days rather than later.

In the case of a nonrelative independent adoption the proposal requires the use of a two-stage surrender. First the surrender operates in favor of the adopting parents and places a condition upon them to initiate adoption proceedings in the Superior Court within 60 days following the date of the surrender. The second stage of the surrender comes into effect if, and only if, the adopting parents fail to satisfy this condition. In that event, the surrender operates in favor of the Department of Human Resources in order to afford the child protection. The two-stage surrender is designed to correct the "limbo" problem which exists in many independent adoptions. A child is in legal "limbo" following the execution of the surrender by its biological parents and prior to the consummation of the adoption proceedings. During that period no person is actually standing in the position of legal parent to the child. Cases arise wherein the child develops serious medical problems soon after placement and the adopting parents decide they cannot cope with the additional burdens represented by the medical problems. They in effect abandon the child and the Department of Human Resources, which is charged by law with the responsibility of protecting such a child, has to go through numerous legal procedures and delays in order to secure the requisite authority over the child to arrange for its care, including possible adoption by another. The two-stage surrender would correct this deficiency and would afford additional protection for the child without impeding the independent adoption process.

The proposed legislation contains provisions designed to curb "black market" adoption activity through the requirement of financial disclosure. It requires that the adopting parents disclose to the court, under penalties of perjury, all financial arrangements made with respect to the adoption of the child. Provision is also included requiring that the attorney for the adopting parents disclose all consideration received by him, for whatever reason, in connection with the placement of the child and the prosecution of the adoption petition.

Rights of Putative Father

The proposed legislation addresses the rights of the putative father, a particularly difficult area of the law. Present Georgia law requires that only the mother of an illegitimate child need consent to that child's adoption. However, since 1972 when the United States Supreme Court rendered its decision in *Stanley* v. *Illinois*[2] and *Rothstein* v. *Lutheran Social Services of Wisconsin,*[3] an uncertainty has existed with respect to adoptions wherein the rights of both the biological mother and father have not been addressed. The proposal requires that, under certain circum-

stances, the putative father be given notice of the pending adoption proceeding or of the proceeding to terminate the biological mother's parental rights, and places the burden upon him to take the affirmative step of legitimating the child before he has the rights of a parent to object to the adoption. This section attempts to strike a delicate balance between the child's right to a prompt and secure placement and a putative father's right to notice. The Supreme Court has not provided guidance as to the scope and method of protection to be offered the putative father's rights. Since 1972 the Department of Human Resources has attempted, in connection with agency adoptions, to notify the putative father whenever possible, in an effort to assure a secure placement for the child. The proposal provides for uniformity in this area. The proposed legislation does not require that the biological father be notified in every case, but only requires notification where the putative father has demonstrated his interest in the child in a tangible way. The proposal contains a provision whereby the biological mother, through sworn affidavit, has the option either to identify the biological father or to withhold such identification, thereby protecting her right of privacy.

The proposal contains a provision designed to afford the Department of Human Resources or licensed child-placing agency, which is charged with the responsibility of protecting the interest of the child in the adoption proceeding, the right to have appellate court review of any adverse decision rendered by a Superior Court.

The proposal clarifies the effect of a decree of adoption relative to the termination of inheritance rights between the child and his biological parents. This rectifies an ambiguity which exists under present law between a child whose parental rights are terminated in a Juvenile Court proceeding and then placed for adoption and a child who is placed for adoption through a voluntary surrender. In the former the child's inheritance rights are terminated, wherein the latter they are not. No reason exists for such a difference. An exception is made in the case of a child whose biological parents are deceased at the time the decree of adoption is entered, not terminating that child's inheritance rights from his biological parents.

Conclusion

The proposed legislation to be introduced in the Georgia General Assembly in January, 1977 effects a comprehensive revision and modernization of Georgia's adoption laws and is designed to balance the interests of the biological parents, the child and the adopting parents. It should have little or no effect on the medical profession in the State of Georgia but will work to protect the rights of those who are involved in the adoption process. ■

REFERENCES

1. H. B. 1712.
2. *Stanley* v. *Illinois,* 405 U.S. 645 (1972).
3. *Rothstein* v. *Lutheran Social Services of Wisconsin,* 405 U.S. 1051 (1972).

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NEW MEMBERS

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Roper, Ronald P., Cobb—Act—U
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VA Hospital, Augusta 30904

Walker, John H., Richmond—Act—Path
VA Hospital, Lab. Service, Augusta 30907

Wirsing, Charles J., Jr., Richmond—Act—P
216 Simmons Place, Augusta 30907

SOCIETIES

For its July meeting, the **DeKalb Medical Society** invited Dr. Judson C. Ward, Jr., executive vice president and dean of faculties at Emory University, to speak on "Bicentennial—1976." The society's Tel-Med service of providing health care information to the public now is sponsored by the society itself and DeKalb General Hospital. The C&S Bank, through its support, had been instrumental in establishing the service. The annual summer outing for DeKalb is scheduled for August 28 and will include a family day at Lake Lanier Island.

The **Georgia Medical Society** sponsored the Fourth Annual Sports Medicine Symposium July 30 for coaches and physicians in the area interested in sports medicine.

PERSONALS

Second District

Two new physicians joining the medical staff of Tift General Hospital are Thomas William Hayes, an otolaryngologist from University Hospital in Jackson, Miss., and Richard E. McCullough, coming from a residency in internal medicine at Memorial Hospital Medical Center in Savannah.

Third District

Fourteen MAG members have completed programs at The Medical Center in Columbus and were awarded certificates recently. Finishing a three-year residency program were **Robert N. Murdock, Joe F. Terrell, Gary A. Dillard, John C. Schnick** and **Donald D. Newman.** Five students have completed the first year family practice residency requirements—**Dennis M. Aguirre, Glenn H. Bartlett, Richard A. Bolen, Joe D. McClinton** and **James E. Lyle. Charles I. Caulton** and **Robert O. House** have completed flexible internships. Two doctors had completed requirements for the three year program earlier in the year and returned for the ceremonies—**Jerry S. Chase** and **Donald B. Waters.**

Fourth District

Kenneth E. Shoemaker is now the director of alcohol and drug rehabilitation services for Peachtree and Parkwood Mental Health Center and Hospitals on Cliff Valley Way in Atlanta. Dr. Shoemaker had served as medical director of the DeKalb County Mental Health and Mental Retardation Services for the past two years. He will be in charge of rehabilitation aspect of Peachtree and Parkwood's alcohol and drug program with T. Albert Davis remaining as director of psychiatry.

Fifth District

New chief of anesthesia at Georgia Baptist Medical Center is **Julius N. Hill, III,** who also serves as medical director for the hospital's School of Anesthesia for Nurses.

John Jay Baker has been appointed to the medical staff of St. Joseph's Infirmary. Dr. Baker is a medical oncology specialist and a graduate of Wayne State University School of Medicine.

Clinical Scalar Electrocardiography, a book by **Bernard Lipman** of Atlanta, has been selected by the American College of Physicians as one of the best for interests specializing in electrocardiography.

Frank T. Espinoza, Atlanta, is a speaker for the 10th World Congress of Gastroenterology in Budapest, Hungary. He will speak on "A New Surgical Approach to Morbid Obesity," later addressing the Medical Society of Vienna on the same subject.

Sixth District

Two new physicians have begun practice in Forsyth: **James D. Lawrence** of Macon will hold office hours three days a week; and **Senen J. Encinas,** a family practitioner, has moved to Forsyth from Louisville.

Seventh District

Noah Meadows of Marietta has been honored by Southern Technical Institute in that city with the Benjamin Franklin Medal. The bronze medallion commends Dr. Meadows for combining knowledge of humanities and technology in service of the community. Dr. Meadows is coordinator of the annual Cobb County Symposium, and a former president of the Cobb County Medical Society.

Eighth District

George E. Mixon has closed his practice in Ocilla and assumed duties at the Veterans Administration Hospital in Dublin.

Tenth District

Luis Arrue now has opened a full time practice in pediatrics in Covington, after working in Jonesboro four years.

Carl Jelenko, Augusta, has been elected to the American Board of Emergency Medicine and to the section council for the AMA on emergency medicine. He will serve on the program committee and the editorial board of *The American Surgeon* for the Southeastern Surgical Congress.

P. D. Webster of the Medical College of Georgia has received an HEW grant for "Control of Pancreatic Ductal and Acinar Cell Function."

DEATHS

Ben Hill Clifton

Ben Hill Clifton, 86, a former president of the Medical Association of Atlanta, died June 26 in Atlanta.

Dr. Clifton retired in 1963 after 51 years as a surgeon. He was graduated from Emory University School of Medicine in 1912. His internship was served at Wesley Memorial Hospital at Emory and his residency at Georgia Baptist. For 26 years Dr. Clifton was on the surgical teaching staff for Grady Memorial Hospital and he was on the staffs of Emory, Georgia Baptist, Crawford Long, Piedmont and St. Joseph's hospitals.

Dr. Clifton was a fellow of the American College of Surgeons and a member of Phi Beta Pi—Theta Kappa Psi medical fraternity.

Survivors include his widow, Mrs. Faye Hollis Clifton; and a sister, Mrs. W. E. Brown, Sr. of Lyons.

CANADIAN CONSUL GENERAL PRESENTS COMMEMORATIVE BOOK TO MAG

MAG President Fleming L. Jolley, M.D. accepts a beautiful, full color book of photographs from Canadian Consul General Harry J. Horne, in a gesture of friendship from Canada during our bicentennial year. The 220 page book presents a panorama of the U.S.-Canadian border from mountain-hugging glaciers to sprawling cities, and the people who live or work near the border.

Titled "Between Friends/Entre Amis," the book is designed to salute the "decades during which our peoples have lived side by side in peace and friendship." Scattered quotations and captions explaining the photographs are printed in English and French, emphasizing the bilingual nature of Canada's population.

The first volume of the book was presented June 16 to President Gerald Ford by Canadian Prime Minister Pierre Elliott Trudeau. Similar ceremonies have followed in every state as some 20,000 copies were distributed to governors, congressmen, civic leaders, and university and community libraries. Additional copies have been made available for sale to the public.

The publication was produced by the National Film Board of Canada, and involved the contributions of 32 Canadian photographers.

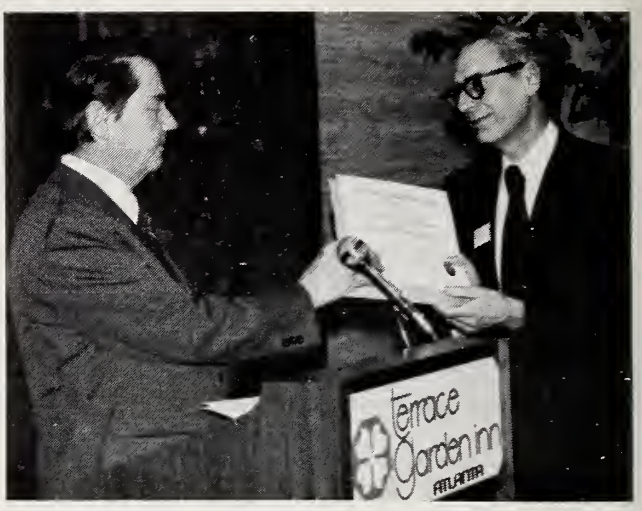


Atlanta is the home of Canada's newest Consulate General opened in September, 1972 at the Coastal States Building downtown. Its duties include services to Canadian citizens in the Southeast, promotion of trade, and assistance for future travelers to Canada.

Accredited CME in Georgia

How do you recognize a continuing medical education program of genuine quality? Only the learner can assess the true value of a learning experience, but the AMA devotes a good deal of effort and expense to a system which helps the physician make choices about the planning of his or her precious time for CME.

The AMA's voluntary system of accreditation for CME employs the same kinds of criteria that are followed in the accreditation of academic institutions and courses. Is the activity well-planned? Does it have a specific objective? Is the educator properly qualified? Is the learner's performance evaluated? Are records kept? These and other questions are posed by the teams of physicians which the AMA sends out to survey the CME programs of various medical institutions. If the survey team report is favorable, the institution is accredited. Such accredition—not to be confused with JCAH accreditation—marks the institution as a dependable provider of quality CME. As of June, 1976, 807 institutions and organizations in the United States have been accredited.



William C. Waters (L), representing the Medical Association of Georgia, presents the AMA certificate of accreditation to Harold McPheeters, chairman of the Georgia Psychiatric Association's Continuing Education Committee.

Since it is not feasible for the AMA to survey every institution requesting accreditation, it has delegated to state medical societies the task of surveying local programs of CME. During the last two years the MAG's Division of Education has been busy in this work, conducting 21 surveys and re-surveys.

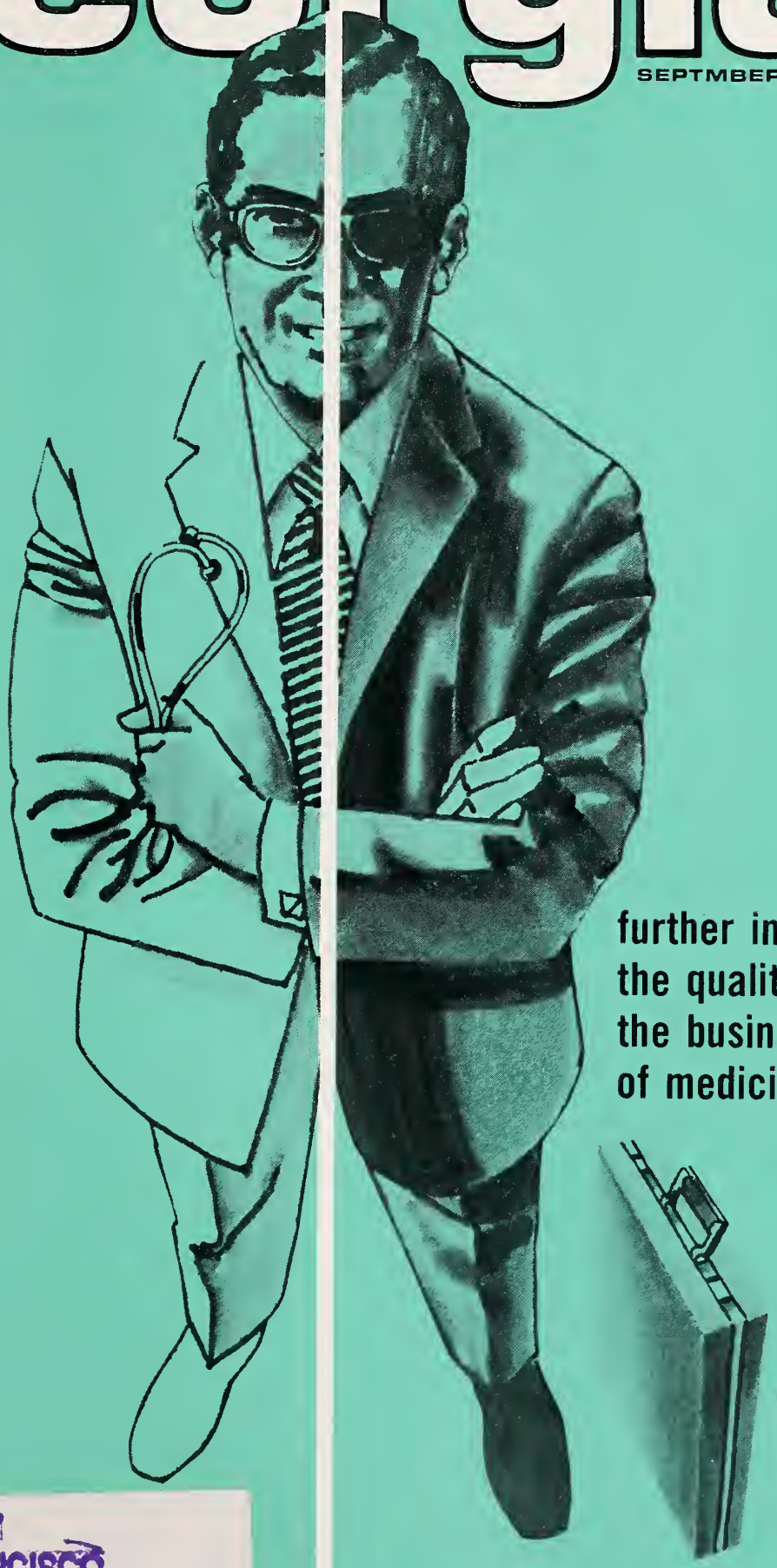
When CME is made a requirement for recertification, relicensure, hospital staff privileges, or membership in a medical society, there is usually a provision that a certain amount of this education be sponsored by an accredited institution. This is what is meant by Category 1 credit. Sixty Category 1 credits, for example, are required for the AMA's Physician's Recognition Award.

Accredited CME may not be readily available in every Georgia locale where a physician lives and practices, but it is becoming much more accessible. The following list gives a good picture of accredited CME programs in Georgia:

Accredited Institution or Organization	*Director of CME*
American Cancer Society, Georgia Division	Shirley Preston
American College of Chest Physicians—Georgia Chapter	William Logan, M.D.
American College of Physicians—Georgia	Nicholas Davies, M.D.
Atlanta Graduate Medical Assembly	Wynell Hopkins
Atlanta Society of Pathologists	David Stacy, M.D.
CDC (National Center for Disease Control)	W. N. Davey, M.D.
DeKalb General Hospital, Decatur	John Harrel, M.D.
Emory University School of Medicine and affiliated hospitals	Bernard Hallman, M.D.
Georgia Academy of Family Physicians	Camille Day
GAFP Educational Foundation	Camille Day
Georgia Baptist Hospital, Atlanta	James Maughon, M.D.
Georgia Heart Association	Jacquelyn Keese
Georgia Psychiatric Association	Harold McPheeters, M.D.
Georgia Radiological Society	William Miller, M.D.
Georgia Society of Ophthalmology	Talitha Russell
Georgia State Obstetrical and Gynecological Society	Chester Lane
Martin Army Hospital, Fort Benning	Cesar Lopez, M.D.
The Medical Center, Columbus	Dan Cabaniss, M.D.
Medical Center of Central Georgia, Macon	Bruce Schieneman, M.D.
Medical College of Georgia and affiliated hospitals	Glen Garrison, M.D.
Memorial Medical Center, Savannah	Carl Rosengart, M.D.
Northside Hospital, Atlanta	Barry Silverman, M.D.
Piedmont Hospital, Atlanta	Mark Silverman, M.D.
Southeastern Angiographic Society	William Miller, M.D.

Inquiries about accreditation should be addressed to: Stephen Daniel, Ph.D., Director of Education, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

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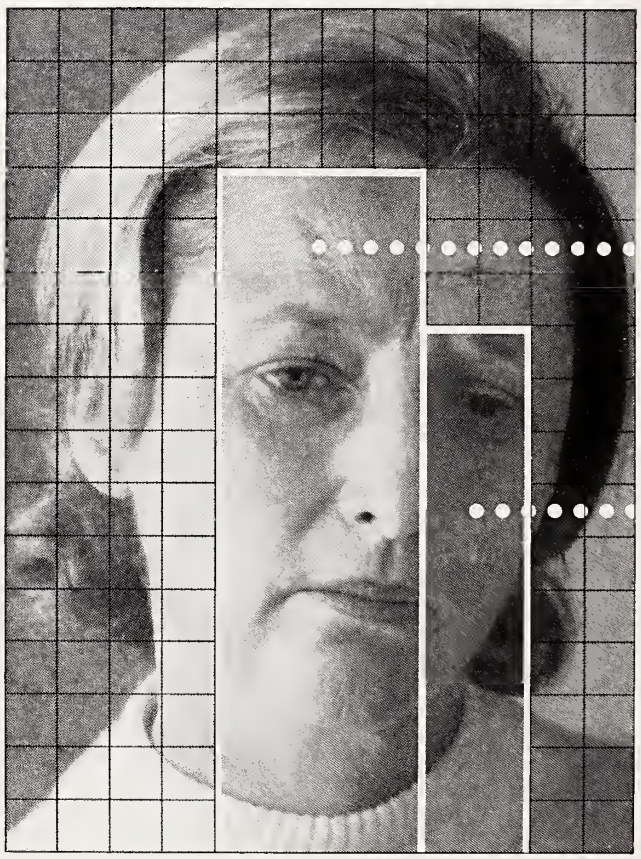


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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdr may be associated with temporary increase in frequency and/or severity o seizures. Advise against simultaneous gestion of alcohol and other CNS depr sants. Withdrawal symptoms (similar those with barbiturates and alcohol) h occurred following abrupt discontinu (convulsions, tremor, abdominal and cle cramps, vomiting and sweating). addiction-prone individuals under car

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THE COVER

MAGNET '76, an annual practice management seminar for physicians and their staffs, will be held in Atlanta next month. The goals of the seminar are to introduce good, sound management techniques into your current office procedure, techniques that will pay off in many ways in addition to improving the quality of care given. A preview article on learning to manage your time begins on page 339, and President Fleming Jolley urges your attendance at the seminar in his letter on page 357.

PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200

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A Little Bit of Time to Manage Your Practice

PRACTICE PRODUCTIVITY INC., *Atlanta**

Our MAGNET Conference speakers have prepared a sneak preview of their program in October. The problems one physician has in managing his practice may sound very familiar to you, and the solutions offered are straightforward and simple.

"She's been with me 11 years, but there are a lot of things she doesn't like to do—so I do them!" Those were the words of my high school chum, Dan, who went into medicine when I went into business. Now that I'm in medical management consulting we have had a lot of conversations about practice problems. This one continued as follows:

"Have you told her that you expect these things from her?" I asked.

"No, but last Monday I blew my top when she wouldn't call the hospital to admit a patient," Dan said.

"Why wouldn't she call?" was my next question.

"There's a nurse working on the surgical floor who used to work for the G.P. next door. They had a falling out while she worked over there. Some squabble about the use of the parking lot."

"So—who admitted the patient?" I asked.

"I did," said Dan.

"Why?" I queried.

"Because it's quicker than fussing for an hour or two," Dan retorted.

"Another thing that irks me," he said, "my schedule is so jammed up I can't handle the load any more. So I thought I'd better start giving up my afternoon off—at least until the first of the year—just to get caught up."

"A noble sacrifice on your part," I commented.

"Yeah. Except for one thing. *She* won't give up *her* afternoon off. That's when she does all her family shopping," said Dan.

"What are you going to do about it?" was the next obvious question.

"Nothing. But it sure makes me mad!" concluded Dan.

Our most recent conversation was about Dan's personal life. His children are now teenagers and he was feeling guilty about the small amount of time he spent with them.

"Get your priorities straight," I admonished.

Somehow he couldn't get the connection I described between his current problem and the earlier one.

Dan had long ago lost control of the management of *his* most precious commodity—*time*.

Poor Disciplinarian

That's not all that unusual. The very nature of the physician, who chose his career because he *cares* about people, tends to cause him to be a poor disciplinarian. He often can't say "no." He continues to accept duties and obligations, as well as new patients, until physical, emotional, or family stress causes him to pause.

Dan and I discussed both problems. He never did solve the first one. I tried to refresh his memory about various developments that arose as he lost control of various segments of his practice and time.

The eternal busy signal on the phone was the beginning. Dan often fielded 35 calls a day himself. The patient was put right through. Dan spent about

---

* Practice Productivity Inc. is a management consulting firm offering educational and motivational workshops on sound business concepts for physicians and their assistants. Members of the Practice Productivity staff will be the featured speakers at the MAGNET Conference, October 23 and 24, 1976 at the Hotel Sonesta, Atlanta. The address of Practice Productivity Inc. is 2000 Clearview Ave., Suite 101, Atlanta, Ga. 30340.

25 percent of his office day on the phone. A good many calls were patients whom he had told "call me in a week and let me know how you're doing"—so they did!

His schedule was always behind. He arrived late in the morning and again in the afternoon because of all the meetings he had to attend. He served on seven committees at three hospitals and was chairman of two. He volunteered as a section chairman for the United Fund, served as a director of a children's home and was active in his church.

But his worst problems were in the management of his own office. Instead of taking a little bit of the time he "gave away," and trying to put some structure in the office, he continued along, buried in frustrations.

No wonder the office operated poorly. Nothing was in writing. Nobody had job descriptions. Tasks were not defined. The personnel decided what they would or would not do; and there was a lot of bickering about it.

Dan had really lost the grip on his own life. Presently he is responding to every need of every patient or future patient, but not to those of his family. His approach to practice has become frenzied. He is forever playing "catch-up." The *joy* is gone.

Surprisingly, it would take only a little time to turn it around. By following simple rules, Dan could have his life in order within 90 days.

1. Set Goals, Write Them Down!

Using realistic projections of professional and personal goals, define the really important things you desire to achieve.

2. Limit the Number of "Things" on Which You Focus Your Attention.

You cannot say "yes" to every hospital, committee, and agency that desires your participation. Learn to say "no" when that is appropriate in light of your goals.

3. Manage Your Practice!

Give it some of the time you are putting elsewhere. Your people cannot serve you or the patients well if they don't know what you want.

4. Create Communications.

Structure it since it does not automatically happen. Plan meetings with colleagues and staff on a regular basis. *Help them solve your problems.* Listen to problems. Investigate solutions. Develop plans. Structure the implementation of those plans.

5. Delegate Responsibility.

Surround yourself with good and capable people. Then challenge them with interesting tasks. Make sure you give them proper training to do the tasks well.

6. Reward Good Performance.

It may be a bonus or a "thank you." But good performance needs to be reviewed and reinforced. Poor performance must be discouraged.

7. Reflect on Yourself!

Don't expect others to change until they see proof of change in your habits.

You are the leader of your practice! If you offer no leadership, those following you will certainly stray. People tend to lower the quality of their work to meet your expectations.

Take a few minutes out of your life to get a grip on it. Decide whether or not you want to run yourself into the ground. But don't let others do it to you.

Dan hasn't had enough crises yet to change his life.

Today is your chance to change your thinking and your life. ■

MAGNET '76

PHYSICIANS, PEOPLE AND MONEY:

Building a More Effective Practice

A Practice Management seminar sponsored by the Medical Association of Georgia for physicians and their staffs. Registration forms have been mailed to all members.

OCTOBER 23-24, 1976 **HOTEL SONESTA, ATLANTA**

Corner of Peachtree and Piedmont roads, next to Tower Place.

This statement has been prepared by the Public Health Service of the Department of Health, Education, and Welfare, headquartered in the Atlanta Center for Disease Control.

Rationale for Swine Flu Mass Immunizations in 1976

INFLUENZA IS A recurring health problem each year, primarily because the virus that causes influenza constantly undergoes minor changes. For this reason, vaccines must continually be revised to provide protection against the altered influenza strains. Each year when variations in the virus are identified, efforts are made to develop updated vaccines and to selectively immunize the high-risk groups that are particularly susceptible to the effects of infection.

In addition to the constant minor changes in the influenza virus, it has been observed that periodically *major* changes in the virus have occurred. Because the population has no established immunity to the new virus, the disease spreads quickly and influenza pandemics (major epidemics that spread worldwide) invariably occur. This happened in 1957 and 1968, and resulted in extensive illness and death. In each of these pandemics, recognition of the major change in the virus was possible only when outbreaks had already begun to occur and spread rapidly through the susceptible population—too late for development and administration of vaccines to protect against the new strain and significantly alter the course of the pandemic.

In 1976, there is evidence that a major new virus has been identified, possibly early in its ecologic cycle, prior to the beginning of pandemic spread. For the first time, health personnel have the necessary lead time as well as the scientific and technological capacity to develop, produce, and distribute a vaccine to protect the population against what appears to be a newly emerged strain of influenza virus with potential for pandemic spread.

Potential for Pandemic Occurrence

Influenza outbreaks occur annually in the United States. The virus that causes this disease is constantly changing, thus preventing man from building up specific immunity to it. From year to year, the variations in the virus tend to be relatively minor. But periodically a major antigenic shift occurs in the virus. This major change in the makeup of the virus has thus far always been attended by pandemic disease as a consequence of the population's having no previous exposure to the new antigens and therefore having built up no immunity to the essentially new virus strain. This is what happened in 1957 with the Asian flu and again in 1968 with the Hong Kong flu, when pandemics resulted in extensive illness and death.

Variations of the Hong Kong flu subtype have prevailed throughout the world since 1968, but in February, 1976, a new influenza subtype that was very different from the prevailing variation of Hong Kong strain (A/Victoria) was isolated at Ft. Dix, New Jersey. The influenza outbreak at Ft. Dix occurred among military recruits; one young man died and several hundred were found to be infected with a new strain of human influenza A virus, A/New Jersey/8/76 or swine influenza virus. The new virus was unlike the other influenza strains that had been circulating through the population. A major antigenic shift appeared to have taken place. On every occasion in the past when a major shift has been identified, a pandemic has followed.

The A/New Jersey virus identified in the Ft. Dix outbreak is similar to the strain that causes influenza in swine and is also similar in some ways to the virus suspected to be the cause of the great 1918 influenza pandemic. This suspected similarity is based on the fact that many persons who were alive during the 1918 outbreak and the years immediately following carry antibodies to a swine influenza-like flu virus in their blood. Almost no one born since 1930 has these antibodies.

Although the swine influenza virus disappeared

from the human population in 1929, it has continued to occur in swine. Because swine-to-man transmission of swine influenza has rarely been documented, the Ft. Dix epidemic was particularly interesting—especially in the absence of contact with swine. The infection of several hundred soldiers was clear evidence of man-to-man transmission and of the fact that the swine influenza virus at Ft. Dix was indeed a human pathogen.

The surveillance data suggest that while there was only the one outbreak of A/New Jersey occurring at Ft. Dix toward the end of the influenza season, there may well have been more general seeding of this virus, i.e., isolated cases occurring in scattered communities. This raises two possibilities, both without precedent in the history of influenza: 1) due in part to improved surveillance, a new pandemic strain may have been identified at a point in its ecologic cycle prior to the beginning of pandemic spread; or 2) an antigenically new influenza virus may have caused disease in a highly susceptible population but failed to spread further. While the second possibility is recognized, it has never before been known to happen.

The hypothesis that there will be an influenza pandemic caused by A/New Jersey strains will remain debatable until additional outbreaks begin occurring. Scientists cannot say with certainty that this new virus strain will spread to the general population during the influenza season. However, it should be noted that every time there has been a major change in the influenza virus, a major epidemic has followed. The ingredients for a pandemic clearly exist: an antigenically new influenza virus, a susceptible population, and demonstrated capability for human-to-human spread of the virus.

Anticipated Impact

The remarkable speed with which influenza may spread is unique in the history of infectious diseases. If the newly identified influenza A/New Jersey does reappear in the human population, it could quickly develop into a worldwide epidemic strain, capable of causing extensive illness and death. In the well-documented pandemic of 1957 and 1968, the time from the initial reporting of isolation of a new strain of influenza to the dissemination of disease to all major areas in the world was less than 6 months. The reasons for the rapid spread of influenza are only partially understood. Unquestionably important factors are the short incubation period (24-48 hours), the large populations susceptible to infection, and the ease with which the disease is transmitted.

Surveys among the United States population suggest that only persons over age 50 have any antibodies to a virus similar to A/New Jersey. Therefore, essentially those under age 50 are presumed to be susceptible to it. Previous experience with other influenza strains has shown that even among those over 50 who have antibodies to swine influenza-like virus, little residual resistance to the infection can be relied upon. For this reason, and because the older age groups face the highest risk of fatal complications resulting from infection, they, too, must be considered vulnerable to infection with swine influenza virus.

Influenza epidemics characteristically cause illness in many people (perhaps 20-30 percent of the population), but death in few (overall death to case ratios of less than one percent). However, there is a higher percentage of mortality in the older population and because so many cases occur, particularly in a pandemic, the actual number of deaths is quite large.

Although individual cases of clinical influenza may be mild, especially in otherwise healthy individuals, the effect of a large number of cases of illness is great. There is increased physician and emergency room utilization and increased absenteeism across the country. Additionally, complications such as bacterial superinfections require longer-term hospitalization.

The impact of influenza pandemics has been measured since the early 1800's by comparing the number of deaths occurring during the outbreak with the number usually expected during that period. Especially evident are excess deaths due to pneumonia and influenza. Mortality is usually highest in the aged and in persons with chronic illnesses such as chronic pulmonary and cardiovascular diseases. While mortality during each pandemic period has been most marked when the new virus strain first appears, as in 1918, 1957, and 1968, excess mortality also occurs in interpandemic years.

The worst influenza pandemic on record occurred in 1918 and caused an estimated 20 million deaths worldwide and approximately half a million deaths in the United States. Estimates for mortality rates in the United States ranged between 400 and 598 death per 100,000, while rates as high as 6,000 per 100,000 were reported from some countries and in some military groups. One unusual aspect of this pandemic was that excess mortality was most evident in persons aged 20 to 40.

It should be pointed out here that although the swine influenza virus identified at Ft. Dix appears to be antigenically similar to the virus that caused the 1918 pandemic, the A/New Jersey strain would not necessarily have the same virulence as the 1918

virus. It is not possible to assess the virulence of an influenza virus in advance of its epidemic occurrence in large numbers of people. However, any pandemic virus can be expected to result in thousands of deaths and millions of cases of illness.

The A/New Jersey virus may not prove to be of unusual virulence, but could pose the same sort of threat experienced in 1957 when the new Asian influenza virus first appeared. During this pandemic, excess mortality in the United States during the winter of 1957-58 was estimated at 69,800 deaths. In the 1968 pandemic caused by Hong Kong influenza virus, an estimated 33,800 excess deaths occurred.

Although the total monetary costs of influenza pandemics cannot be precisely calculated, an estimate based on a 10 percent sample of final morbidity and mortality data was made of the cost of the 1968 Hong Kong pandemic. The estimated costs of physicians visits, hospitalization, prescriptions, and loss of earnings amounted to $2.6 billion. Using the preliminary estimate of 27,500 excess deaths, the estimated cost from loss of earnings alone was $1.3 billion for a total estimated cost of $3.9 billion for the 1968 pandemic in the United States. Because final data showed an even greater number of deaths (33,800), actual costs were even higher than this estimate.

Vaccine Effectiveness, Complications

Influenza vaccines produced today offer greater protection with fewer side effects than did vaccines of the past. This is the result of improved techniques in vaccine purification. Extraneous material in early influenza vaccines was a frequent cause of side effects. Since the early 1970's it has become possible to increase the purity of flu vaccines, allowing for both an increase in antigen content and a reduction in adverse reactions.

It is estimated that at least 70 percent of the individuals receiving the A/New Jersey influenza vaccine will be fully protected against that strain for the coming fall and winter influenza season. Because a new virus usually does not change significantly for several years, substantial protection against A/New Jersey-like strains could be expected to persist for as much as 3 years. The degree of effectiveness of this vaccine may be somewhat greater than that for other recent flu vaccines. When a fresh strain of flu is identified (e.g., swine influenza) with markedly new antigens, it is possible to develop a vaccine which is very specific to those antigens and therefore highly effective.

Field trials have recently been conducted to determine the most desirable dosage of swine influenza vaccine, i.e., the amount of vaccine which will produce an acceptable level of antibodies with a minimum of side effects. No one will contract flu from receiving the vaccine because it contains a killed virus. People who are allergic to eggs are advised not to be immunized except under the close supervision of a physician because the vaccine virus is grown in chick embryos.

For all other individuals for whom the vaccine is recommended, side effects should be minor. Most adults over the age of 25 will experience no reaction at all. A small number may have a slight fever, headache, chills, or muscle aches which should subside within 48 hours. About 1 percent may run temperatures over 100 degrees. Perhaps 25 percent will experience transient swelling, redness and tenderness in the arm.* The discomfort or fever can be easily controlled with aspirin. More serious reactions are extremely rare, and there have been only two reports of fatal reactions associated with influenza vaccine, both occurring in the early days of vaccine usage. No such reports have been documented since 1946.

Scientists cannot say with certainty that the newly identified A/New Jersey influenza virus strain will spread to the general population during the fall and winter flu season. However, every previous major change in the makeup of the influenza virus has been followed by a major epidemic.

For the first time, early identification of what appears to be a newly emerged flu virus has provided health personnel with the lead time needed to develop, produce, and distribute a vaccine to protect the population against an influenza virus with potential for pandemic spread.

The crucial public health question of whether or not to produce A/New Jersey vaccine and recommend its widespread administration in response to the *possibility* of a pandemic was considered in light of the potential costs and benefits of immunizing vs. those of not immunizing. If the A/New Jersey virus does reappear in the population, the immunization of most United States citizens with the new flu vaccine will prevent thousands of deaths, millions of cases of illness, and the loss of billions of dollars. There would still be some cases of flu, even among those immunized, but the number of cases would be greatly reduced. Alternatively, the effort will have been in vain if spread of the virus does not extend to the general population during the period of vaccine effectiveness. To gamble with the cost in lives, illness, and economic loss compared with the relatively modest expense of implementing this preventive action would be irresponsible.

The decision has been made to produce vaccine

* The description is that of side effects resulting from influenza vaccines of recent years—there is no reason to believe the swine influenza vaccine will differ significantly in its potential side effects.

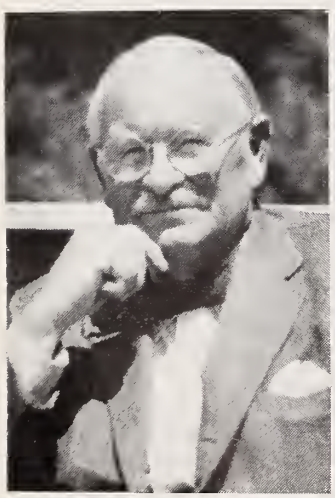
sufficient to offer immunization against A/New Jersey to all persons in the United States and to provide high-risk groups with protection against both the new virus strain and the A/Victoria strain which was prevalent in 1975-76 and which may persist to some extent in 1976-77. Monovalent B influenza vaccine should be considered for the high risk groups as well. That is, those over 25 years of age and chronically ill. It is available through commercial channels.

No reasonable alternative to the selected course of action can be justified on epidemiological groups. There is no basis for selective immunization of any part of the population against A/New Jersey. The alternative of doing nothing and gambling that a pandemic will not occur could result in extensive deaths and illness and cost billions of dollars.

Some have suggested that plans be readied for a mass immunization program and that vaccine be produced and stockpiled but not administered until there is documented reoccurrence of A/New Jersey influenza in the population. To delay immunization until such a time may seem at first thought to be ideal. However, such an approach would be a race against time and could fail to be effective in controlling the spread of disease for a combination of reasons. Although flu epidemics are generally preceded by a small number of sporadic cases, influenza caused by a new virus spreads throughout a population with great rapidity. In past instances, the time from introduction of the virus to widespread epidemic occurrence has been approximately 11-12 weeks. Even if vaccine has been stockpiled and plans readied for a mass immunization program to begin at the first sign of transmission, it is estimated that at least 11-13 weeks would be required to distribute vaccine from central storage areas, mobilize teams into an operational state, and immunize people with the vaccine. Additionally, about 2 weeks after immunization are required for influenza vaccine to attain its maximum effect. Even with the best of preparations, a wait-and-see approach would clearly be a race against time. The sheer logistics of immunizing 20 million people make it mandatory that the program be initiated before influenza appears. To do otherwise could be ineffective in protecting the population and would still involve large monetary costs.

The mass immunization program is clearly a calculated gamble. An epidemic caused by A/New Jersey/8/76 may not occur. However, there is no middle ground and the stakes are very high indeed if an immunization program is not conducted and an influenza epidemic occurs. It would be better to have an immunization program without an epidemic than an epidemic without an immunization program. ■

OCTOBER INSTITUTE TO FOCUS ON MEDICAL DECISIONS



"Decision-making in Health Care" will be the subject of a special one-day institute for physicians, nurses, and other health professionals on Saturday, October 16. The institute, co-sponsored by the MAG and Emory University's Division of Community Education, will be held at the Century Center Motor Hotel in Atlanta.

Featured guest speaker will be Joseph Fletcher, the noted moral theologian and medical ethician. Dr. Fletcher has authored seven books, including the ground-breaking *Situation Ethics* (1966) and *The Ethics of Genetic Control* (1974). He is presently Visiting Professor of Medical Ethics at the University of Virginia, School of Medicine, and has lectured in some 90 colleges and medical schools in the United States, Asia, and Europe.

The institute will incorporate several case studies and an interdisciplinary methodology, with panelists expert in the scientific, legal, economic, institutional, and social aspects of decisions in the health care setting.

Partial funding for the institute has been made available through a grant under the Higher Education Act of 1965.

For information about registration, contact the coordinator of the institute, Dr. Stephen Daniel, at the MAG office in Atlanta, (404) 876-7535 or 800-282-0224 (WATS).

A survey from 1974 shows a general support of the P.A. concept, with questions about legal liability, training and duties.

An Attitude Study of the Physician's Assistant in Georgia

JOHN W. YOUTSEY, Ed.S., A.R.R.T., *Atlanta**

DURING THE LAST several years, America's health professions have faced numerous problems. The high cost of health care continues to rise almost in an exponential fashion. Greater demands are being made upon the physician for better and more comprehensive services; while, at the same time, the physician is being frustrated through increasing losses from malpractice suits, difficulty in obtaining liability insurance, and a growing skepticism on the part of the patient and general population. The old problems that continue to face the medical profession emphasize the lack of supply, distribution, organization, utilization, and financing of physician services.[1]

The problems of health care are not differentiated; but, rather they are interrelated and dependent. The problems are demonstrated in overburdened physicians, rapidly rising medical costs, lack of appropriate use of equipment and facilities, lack of any medical care in many rural areas, maldistribution of physicians in urban areas, and delays in seeking medical care by the population.

Georgia is no different than most states with respect of these health care delivery problems. With only two four-year medical schools in the state and only one of these being a state supported school, not enough physicians are being produced to meet the needs of the Georgia population. Along with most states, Georgia suffers from maldistribution, overspecialization, lack of comprehensive preventive medicine, and prohibitive medical costs.

The trend toward the transfer of medical tasks to non-physicians, initiated in the 1960s by Dr. Eugene Stead at Duke University, has been one way in which to increase the productivity in the health care system.[8, 9] The delegation of tasks from physicians to non-physicians has been slow and many factors are involved.[5]

This study was undertaken in order to determine the impressions of practicing, licensed physicians in Georgia concerning the utilization, roles and acceptance of the physician assistant concept.

The population for this study consisted of a 10 percent random sample of physicians practicing in Georgia during 1974, using the appropriate professional directory. The questionnaire utilized was constructed and items selected on the basis of job descriptions, tasks, and functions presented or proposed, in some form, in clinical settings, or in physician's assistant training programs, and by physician's assistants throughout the country. A questionnaire with an explanatory letter and return envelope was mailed to each of the physicians. No attempt was made to striate the physician sample by medical specialty.

Results

Some 390 questionnaires were mailed to physicians. Of these, 175 were returned, representing a 44.9 percent questionnaire return. Tables 1 and 2 give a breakdown of the physician sample by medical specialty and age. Under the category of "other" in Table 1, includes the medical specialties: thoracic surgery, anesthesiology, radiology and pathology. Of the physicians surveyed, 11.4 percent practiced general medicine and 8.6 percent general surgery. It was also observed that 27.4 percent of the physicians were between 41-50 years of age and 28.0 percent were between 51-60 years old. Tables 3 and 4 give a further breakdown of the physician sample by years in practice and the type of practice. Nearly 32 percent have practiced medicine for over 25 years and 44.6 percent of the physicians sampled practiced alone. Almost 59 percent of the physicians practiced

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in urban areas with greater than 100,000 population and only 4 percent of the physicians were practicing in areas of 5,000 or less population. In addition, 94.3 percent of the physicians were located within 10 miles of a hospital. Only one physician sampled was located more than 40 miles from a hospital. Interestingly, almost 67 percent of the physician sample were physicians while in the military service and nearly 5 percent were medical corpsmen.

Analysis of Data

An analysis of the data revealed that 78.9 percent of the physicians sampled agreed with the philosophy of the physician assistant concept. The vast majority of physicians felt that the training of the physician assistant must be through approved practical training programs and 73 percent felt that these programs should be under the direct supervision of medical schools. The physicians (85 per cent) felt that standardization in terms of program content was desirable. Of the physicians sampled, almost 90 percent felt that the physician assistant should work only under the direct supervision of a licensed physician. Of all the physicians sampled, nearly 35 percent felt that the widespread use of the physician assistant would reduce the present quality of health care.

At the present time, legal liability for the physician is a crisis topic. In relation to the area of legal liability, only 22 percent of the Georgia physicians felt that the physician assistant should be legally responsible for his or her performance while 88 percent felt that the P.A. should be licensed.

Almost 66 percent of the Georgia physicians felt that the P.A. should be permitted to write certain prescriptions. In addition, only 35 percent said that the P.A. should be able to write patient orders in the hospital. Nearly 40 percent said that the P.A. should be permitted to make routine hospital rounds in place of the physician.

The majority of Georgia physicians (83.4 percent) felt that the P.A. should be able to detect abnormal signs and symptoms and 62 percent felt that the P.A. should be able to make preliminary diagnoses based on the patient's examinations and report these on the patient's permanent records or charts. The majority of physicians (58.3 percent) did not feel that the P.A. should have the responsibility for the treatment of patients with minor chronic illnesses. Nearly 55 percent of the physicians surveyed felt that their patients would accept the P.A. to take care of them when they were sick.

Approximately 64 percent of the physicians surveyed felt that the role of the physician assistant overlapped that of the registered nurse.

TABLE 1

A BREAKDOWN OF THE GEORGIA PHYSICIAN SAMPLE BY MEDICAL SPECIALTY

Specialty	Absolute Frequency	Relative Frequency (%)	Adjusted Relative* Frequency (%)
General Medicine	20	11.4	12.3
Internal Medicine	30	17.1	18.5
General Surgery	15	8.6	9.3
Obstetrics and Gynecology	19	10.9	11.7
Pediatrics	10	5.7	6.2
Psychiatry	8	4.6	4.9
Public Health	2	1.1	1.2
Other	58	33.1	35.8

Valid observations = 162
Missing observations = 13
* Adjusted for missing observations.

TABLE 2

A BREAKDOWN OF THE GEORGIA PHYSICIAN SAMPLE BY AGE

Age (Years)	Absolute Frequency	Relative Frequency (%)	Adjusted Relative* Frequency (%)
21-30	3	1.7	1.7
31-40	39	22.3	22.4
41-50	48	27.4	27.6
51-60	49	28.0	28.2
61-70	26	14.9	14.9
over 70	8	4.6	4.6

Valid observations = 174
Missing observations = 1
* Adjusted for missing observations.

The most quoted salary range for the physician assistant was in the $10,000 to $12,000 range (41.7 percent). In addition, 12.6 percent stated that they presently employ a physician assistant, most of whom were registered nurses.

Most Georgia physicians said that if they were to hire a P.A., they would devote more time to community affairs (32.6 percent), while 20 percent would devote more time to further continuing education in medicine, 10.9 percent would spend more time to existing patients, and 13.1 percent would devote more time to their family responsibilities.

When asked about the present state of the American health care system, 59.4 percent felt that the health care system needed to be restructured in order to better meet patient needs.

P.A. Concept Unclear

The concept of what a physician assistant really is or is supposed to be is not consistent within the medical profession or within the allied health profes-

TABLE 3

A BREAKDOWN OF THE GEORGIA PHYSICIAN SAMPLE BY YEARS IN PRACTICE

Years in Practice	Absolute Frequency	Relative Frequency (%)	Adjusted Relative* Frequency (%)
1- 5	20	11.4	11.6
6-10	22	12.6	12.7
11-15	31	17.7	17.9
16-20	20	11.4	11.6
21-25	24	13.7	13.9
over 25	55	31.4	31.8

Valid observations = 173
Missing observations = 2
* Adjusted for missing observations.

TABLE 4

A BREAKDOWN OF THE GEORGIA PHYSICIAN SAMPLE BY TYPE OF PRACTICE

Type of Practice	Absolute Frequency	Relative Frequency (%)	Adjusted Relative* Frequency (%)
Alone	78	44.6	46.4
Multi-Specialty Group	5	2.9	3.0
Same-Specialty Group	52	29.7	31.0
Clinic-Hospital Center	28	16.0	16.7
Medical Education Only	1	.6	.6
Retired	4	2.3	2.4

Valid observations = 168
Missing observations = 7
* Adjusted for missing observations.

sions for that fact. The physician assistant concept has been with us for nearly 10 years, yet it has still to be accepted and utilized efficiently. At present, the legitimate framework for the physician assistant is strong. "Essentials" developed by the AMA now exist for P.A. training programs.[10] Professional roles have been defined by both the AMA and the Federal Government. Presently, a national organization exists called the American Association of Physician Assistants. In spite of such a background, the role of the physician assistant is vague to the physician and the relationship between the two will vary considerably. Each P.A. must individually gain this trust and respect of the physician. When this is achieved, the delegation of responsibility follows. Nurses and therapists generally enter the health system with a certain amount of respect based upon their credentials. The P.A., at present, does not enjoy such status.

Only about 22 percent of the Georgia physicians surveyed felt that the P.A. should be legally responsible for his or her performance. In most states, physicians have the right to delegate medical functions to qualified persons. It is expected that the physician be familiar with the qualifications of the health person being given the functions. The right of all physician assistants to assume their job functions and professional roles comes from the physicians privilege to delegate job functions. With the increasing numbers of allied health professionals and physician assistants being trained, the crisis in malpractice and liability insurance, and increasing governmental involvement in health care delivery, the subject of sole legal liability is becoming extremely important.

Since the basic philosophy of the physician assistant concept concerns primary patient care, the patient-oriented function of the physician assistant is very critical. Nearly 66 percent said that the P.A. should be able to write certain prescriptions and 35 percent of the physicians said the P.A. should be able to write patient orders in the hospital. Often, a resistance exists to the transfer of job functions when the transfer is felt to be a surrender rather than a delegation. The response to this study would indicate that a substantial number of physicians see this as a delegation of authority and not one of surrender.

Nearly 84 percent of Georgia physicians stated that the P.A. should be able to detect abnormal signs and symptoms and make preliminary diagnoses based on such results and report these on patients' permanent records and charts. This would clearly indicate an expanded and developing role for the P.A. in primary patient care. Approximately 54 percent of the Georgia physicians said that their patients would accept the P.A. to take care of them when sick.

When asked whether they felt that the P.A. and R.N. had overlapping roles, 64 percent agreed. The results of this study indicate that the majority of Georgia physicians approve of the concept of the P.A. and hold a positive view of such a person as a primary health practitioner. It is extremely interesting that most physicians would be in favor of a concept which they feel overlaps a pre-existing profession. Replication of services and job functions is a major problem in health care. The lack of standardized job descriptions and evidence of need for services is responsible, in part, for the problem.

Almost 60 percent of the Georgia physicians sampled felt that health care delivery services need to be restricted. Most felt that the widespread use of physician's assistants would not reduce the present quality of health care. These observations suggest an awareness that much of the activity which dominates a physician's schedule can be performed by someone other than a physician. ■

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AAP TESTIFIES ON NATIONAL CHILD HEALTH CARE PROPOSAL

(Prepared by the Department of Communications of the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204.)

A national program of comprehensive health care for all children and pregnant women has been commended by the American Academy of Pediatrics for its emphasis on health supervision and preventive medicine in hearings before the House Subcommittee on Health and the Environment.

Former AAP President R. James McKay, Jr., M.D. and Donald Corneley, M.D. appeared at the subcommittee's invitation in June to respond to provisions of the Maternal and Child Comprehensive Bill of 1976 (HR 12937), sponsored by Rep. James H. Scheuer (D.—N.Y.). A report of the testimony was included in the August issue of *News and Comment,* the AAP's monthly news and feature publication.

The Scheuer bill would create a Maternal and Child Health Board within the Department of Health, Education, and Welfare (HEW) to oversee a national health program for children which would cover screening and preventive health measures for children, as well as office visits, hospital services and surgery. The program would also include maternity benefits, and would be financed by both a federal payroll tax and general revenue funds.

Dr. McKay told the subcommittee that the bill's provisions for comprehensive health care for children were "basic in any national health insurance program. By including coverage of child health supervision under any national health insurance program adopted, children will be kept healthier, will be assured of fuller participation in life, will be assured of the prevention or early alleviation of disease and suffering, and costly hospitalization will be minimized."

As an example, he cited the cost-effectiveness of immunization programs including the national immunization effort against measles, which saved an estimated 1,000 lives and $423 million between 1963 and 1968. He also noted that up to 60 percent of children's chronic, handicapping conditions could be corrected or prevented by a program of continuing, comprehensive care.

"It is thus clear that coverage of the health needs of children and youth through comprehensive health care services is a corridor to eventual better health for the entire populations," Dr. McKay said.

The Academy did offer specific suggestions regarding certain provisions of the bill, in order to "provide for an even more enthusiastic response from the medical community, and ultimately better serve children and aid their families." Among the recommendations:

1. The extension of benefits from age 18 to 21.

2. The expansion of the advisory committee to the Maternal and Child Health Board from 10 to 18 members, "thereby providing a greater opportunity for participation by individuals in pediatric and obstetric practice in private offices. Their insight and concern should be of particular value as policies are developed."

3. More complete coverage of prescription drugs, psychiatric services and transportation between medical centers as part of the overall benefit package.

4. The provision that screening services "should be within the continuum of care received by children in their medical home, and that such activities should not be conducted independently in isolation from the health service delivery system."

5. The establishment of fee payment schedules "consistent with prevailing fees in the area. The utilization of December, 1974 prevailing fees as a base for a program scheduled to begin in 1978 or 1979 (assuming enactment) would make it difficult for most practitioners to exhibit much, if any enthusiasm for participation."

Whether the Scheuer bill is enacted or not, The Academy said, the government should still establish a Maternal and Child Health Administration within HEW. And, the already-existing Maternal and Child Health (MCH) Program authorized under the Social Security Act should be "modified and expanded." Dr. Corneley summarized the results of an academy study of various MCH programs, part of an AAP report scheduled for publication later this year. The report will include recommendations for changes in the MCH program.

Keeping Up With an Accelerated Association

CARSON B. BURGSTINER, M.D., *Savannah**

The 1976 House of Delegates was faced with one of the greatest challenges ever presented to that body. For the first time in Association history, MAG faced a potentially damaging deficit budgeting position. The available options were clear cut: either to stop providing some of the services offered to members, thereby lessening the benefits, or asking for a dues increase. The House took an aggressive approach and passed a dues increase of $125, making the 1977 dues $225 annually. The reasons for a dues increase at this time extend beyond the deficit.

Over the past four years the activities and involvements of the Association have accelerated at an ever increasing pace. During this time, for instance, we have added to the staff a director of public and professional relations, an assistant executive director for administration and an assistant executive director for education. As a result, we are able to do a more effective job in all these areas.

In the area of communications the Association has taken aggressive stands in the public media to defend MAG positions and distribute information of value to the general public.

In October, 1975 we began an all-member monthly newsletter to provide timely information. Also speeches have been prepared, brochures produced and radio public service messages developed, all designed to better inform those publics we wish to reach.

The communications committee and staff have provided members with outstanding socioeconomic programs designed to improve the medical practice from a business standpoint. We are also making major efforts in providing continuing medical education (CME) programs available to members.

The MAG Education Committee and the staff director are actively involved in developing and offering these CME programs, most of which carry specialty society CME credit hours. The committee is also engaged in the accreditation of CME programs for hospitals and specialty societies.

New Printshop

In the area of administration, the hallmark of progress is the printing services now offered to the Association and individual members. Operating under the name of MAG Services, Inc., the printshop will prove to be a cost effective venture for MAG and another excellent member benefit.

Legislative activities on both the state and national levels have been accelerated in the past four years, with additional monies required to carry out the legislative programs of the Association. MAG members and staff have worked long and hard to improve the legislative posture of physicians in Georgia. Through Association efforts many pieces of legislation that would prove detrimental to doctors have been checked. Progressive malpractice bills and significant changes in the state medical practice act were immediately effective in attacking potential problems faced by medicine in Georgia.

Another major expenditure in the recent past is funding the MAG's lawsuit against the State Medicaid program, seeking relief from restrictive rules and regulations that infringe on the independent judgment of the physician in treating his patient. All of the aforementioned thoughts and concerns were considered by the House in voting for a dues increase. The House also voted into effect other progressive measures affecting membership that will accrue long term benefits.

Unified Membership

The first of these changes was to establish, as Association policy, the concept of unified membership between MAG and its component county societies.

It was never intended that any society chartered by MAG should have members that were not also members of the parent organization. The greatest successes achieved by the medical federation have

* Treasurer, MAG.

come about in large measure due to the "one voice" united front presented. Medicine's experiences with the various governmental agencies have shown an ongoing need for all the support that can be mustered by the profession. Therefore, beginning with 1977 dues statements, members will be joining both the county component society and MAG. The second change made by the House will make it easier for certain members to be active in the Association.

Sliding Dues Schedule

For new physicians just entering practice, the House adopted a sliding dues schedule making it financially easier to join. The new physician will pay one-third of the annual dues the first year of membership and two-thirds the second year. The dues schedule for new doctors will have no effect on the amount charged persons who rejoin or who have been in practice but for some reason never joined previously. Older members will also have benefit of reduced dues.

For the older physician who has reached age 66 and has 10 years of membership in MAG, there will be a 20 percent reduction in the annual dues. The member will receive additional reductions in 20 percent increments each year until age 70 when dues exempt status is attained. If all other qualifications are met at age 70, the member will be eligible for life membership status.

The continuing and increasing demands made on our medical organizations will need to be met with more than money if we hope to gain any substantial degree of success. This means we must attract every eligible physician into our membership and get them actively engaged in bettering our service to the membership and the public.

There are many privileges one may attain by membership in the federation of medicine. We accept them as part and parcel of our dues payments. There are also responsibilities that one must assume. One such responsibility is to be ever on the alert for ways to make the organization more effective. Perhaps the most disgruntled of our members are those who do not take active roles in the shaping of the organization.

What better time than 1976 to think of how a small number of like-minded persons, dedicated to a cause, can change virtually any course of events. We have the goal—preservation of the private practice of medicine (and our profession), and we have an effective conduit through our medical organizations. This can be an unbeatable combination, if we want it to be. We as individuals will decide what course our profession will take. ■

NOTED EDUCATORS TO ADDRESS SCIENTIFIC ASSEMBLY

MAG's 1976 Scientific Assembly, to be held November 19-20 at the Omni International Hotel in Atlanta, has attracted a number of noted physician educators from outside of Georgia. They will present scientific papers to 12 specialty groups at the Assembly.

Guest educators in internal medicine will be Jack Myers, president of the American College of Physicians; Thomas R. Harris, trustee of the American Society of Internal Medicine; Burton Sobel, Washington University, St. Louis; William Hood, Jr., Boston University; Leslie Rose, Hahneman Medical College, Philadelphia; Juha Kokko, Southwestern Medical School, Dallas; Martin Cline, University of California, San Francisco; and Roland Ingram, Harvard Medical School.

Educators in other specialties will be Stephen Wasserman, Harvard Medical School, and Will Sealy, Duke Medical Center (chest disease); John T. Gentry, Buffalo (public health); Frank Benson, Boston University (neurology); Elliott Lasser, University of California—San Diego (radiology); David Zimmon, New York University (gastroenterology); Robert Ackland, University of Louisville (plastic surgery); Robert McLaurin, University of Cincinnati (neurosurgery); Harold Perry, Mayo Clinic (dermatology); and Malcolm Cooper, University of Chicago (nuclear medicine).

A flyer describing the Assembly and containing registration forms has been mailed to all MAG members. The complete program will be printed in the October issue of the *Journal*.

For further information, call the MAG Education Department at (404) 876-7535.

In his inaugural address, Dr. Palmer is optimistic about the future of medicine, especially if its practitioners work together through the AMA.

How Firm a Foundation

RICHARD E. PALMER, M.D., *Alexandria, Virginia

THE HONOR OF ACCEDING to your Presidency comes in a very special season—the high summer in America's remembrance of her past. In the dawn's early light of our republic, there is one face I see with particular clarity and sentiment. He was a Virginian and a staunch friend of our profession. An avid collector and reader of books on medicine, he perceived its potential brilliance as a science in an age when it generally had to fumble in the dark. He gave it his help and even his active hand.

If today we physicians feel that we are fall guys for political desperation, let us ever recall that in the deathless eyes of Thomas Jefferson, we are a vanguard of hope. Indeed, hope was the very heart of all his greatest beliefs. If I were to sum up Jefferson's credo in one line, I would say it was hope based on reason and on faith in one's fellow man.

Yes, let me repeat that: Hope based on reason and on faith in one's fellow man. For that is my key message this afternoon. Today, our nation seems to have lost much of the optimism that inspired its birth and its youth. One familiar reason is that the oceans which used to seclude us are now a mere conduit to the world and all its convulsions.

But an even more compelling reason, I think, is the state of the union. The national government has made itself a rigid custodian of the people's common hopes and horizons. It gerrymanders those horizons to please or tantalize certain groups or to suit its own opportunism. In industry and transportation, in community planning and home construction, in education and health, the federal government has become the chief arbiter of what is desirable and what is possible. It is far less adept in realizing possibilities, however, than in stimulating desires. Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the givers of care.

Government's Dogmatism

You and I and our fellow physicians find ourselves assailed because the principles, the dynamics, and the inescapable costs of medical science cannot easily be accommodated to politican whims and will-o'-the-wisps. And instead of settling for a reasonable adjustment to medical realities, government is becoming steadily more dogmatic. Jefferson recognized the evil that such dogmatism could do to our profession. In one of his most notable documents—the *Notes on Virginia*—he observed: "Was the government to prescribe to us our medicine and diet, our bodies would be in such keeping as our souls are now."

The politicians and bureaucrats, if they are fully conscious of their dogmatism, would contend that it is needed and therefore reasonable. But how much reason was there in the original Utilization Review regulations whereby the misjudgments of lay people could have denied hospital care to the elderly and the Medicaid poor? The courts couldn't see it. How much reason in the Health Planning Act of 1974 with its skyscraper and penthouse of bureaucratic power in contrast with the down-to-earth needs of care? How much reason in the House of Representatives subcommittee report that perverted a tabulation of unconfirmed surgical procedures into a nationwide estimate of unnecessary surgery? How much reason in the Federal Trade Commission complaint against our taboo on unrestricted advertising? Such advertising would pad the demand for our services, pad our costs, and undermine our professionalism.

One lesson is clear from all of this meddling: An unreasonable amount of power in the hands of government is inevitably unreasoning power. And there

* President, American Medical Association, 1976-1977. Delivered at the AMA Annual Meeting, June 30, 1976 in Dallas, Texas.

can be no hope unless it is based on reason. Yet, if I were to say that government is the only threat to our hopes as physicians, I would be giving you a half-truth. For how zealously can we accuse the government of lack of faith in us if we lack faith in one another? How fervently can be accuse Washington of trying to "divide and conquer" us if we are so divided that we are conquerable?

Unified Membership

We physicians need to move within a single framework of determination no matter how we may differ on specific issues or in fields of activity. As President, therefore, I will press strongly for unified membership throughout our federation and unity throughout the ranks of medicine.

To any state and county societies that resist unified membership, I say: This American Medical Association is your child. You created it primarily because you were beseiged by problems that no single state could handle on its own. You created it especially because medical education in 1847 was a muddle and a scandal, because any move to improve standards in any state was met by the outcry that students would be lost to lenient schools in other states. In response, belatedly perhaps, but triumphantly, the American Medical Association helped conceive and achieve the Flexner Report.

Over the years, we have expanded our spectrum to legislation, to professional and pharmaceutical standards, to the socio-economics of health, to every area that invokes or endangers our integrity as doctors to man and to society. We can discharge our responsibilities even more successfully, but only if we have the loyalty of you who fathered us. We can fight all the dragons that beset our profession, but not if your apathy feeds their fires. We are your child. Why abandon us?

To you who are interns, residents, and students of medicine and who may judge us as not idealistic enough or, contrarily, as not militant enough, I have these words to say: We share your idealism. Examine our National Health Insurance bill built on existing private financing mechanisms and the pluralistic delivery system. Examine our energetic advocacy of better emergency and rural care, better Indian and migrant care, and countless other manifestations of human concern. We have been and will be militant in your behalf. We have a Department of Negotiations to help our component societies bargain for better medical care, and they in turn can help housestaff do it.

We cannot, however, condone those economic actions that would fly in the face of patient care, and hence, our common professionalism and idealism. Economic action and bargaining without anti-social behavior, without selfish impulsiveness are the civilized approach. And because that is our approach, it is we of the American Medical Association who are modern, and it is labor unions that tend to be old-fashioned and stale.

To those medical-college faculties that feel aloof from the practicing physician and never mention the virtues of the AMA in their classrooms, I have these words to say: You increasingly are seeing that educational grants from Washington entail control from Washington. That control is steadily encroaching on the purposes and parameters of your curriculums and the internal management of your schools. Your very leadership of your students and the direction in which they are being led are at stake. So, like it or not, you have much in common with the practicing physician, in his struggle to preserve his freedom and his professional integrity. Hence, you have much in common with the American Medical Association. Let us go forward together against the dark, for there can be no whistling in it.

To physicians in general, to AMA members and non-members alike, I have these words to say: We have a great fortress in this federation. But its purpose is the protection, not the domination, of medicine. It protects the right to puruse medicine according to ancient truths and modern realities. It practices no belligerence, except toward those who would bring harm upon our profession and our services.

When harm threatens, we of the AMA fight as hard and as long as we have to. We fight wherever we need to, against an unjust law or regulation or the sinister complexities of the professional-liability crisis and the tort system. The day we filed suit against the Utilization Review regulations was our D-Day, for then we made the courts our second front against federal iniquity. And we landed in triumph! We have carried our courtroom campaign forward, against the MAC regulations and against the Health Planning Act, with all of its high battlements and all of its land mines. Congress and the regulatory agencies have long made us wonder what they will do next. With our new legal militance, we are making them wonder what we will do next.

Yet, no matter how vigorously we fight, our gunfire is Jeffersonian reason. Our National Health Insurance bill, for example, and our National Commission on the Cost of Medical Care are reasonable efforts to find the elusive equation between need and meeting the need. Our proposed 19 amendments to the PSRO, to cite a further example, are a reasonable attempt to make it work and keep it from being abused. No matter how reasonably we fight, there

are physicians who want us to be above the battle, to devote ourselves exclusively to clinical matters. Only by being in the battle, however, can we preserve the right and the freedom to be above it.

Protecting Our Reputation

Our battles are not a stain on the doctor's reputation but a protection of it. The false accusations of unnecessary surgery, the rest of the constant fusillade of abuse, and the flood of intimidating legislation and regulation are all part of a pattern. And that pattern has to be broken, or else medicine will lose its own pattern. So with all the vigor of reason and fact, we have countered the fabrications about unnecessary surgery, other daily lies, and the Federal Trade Commission complaint, which would debase medicine with the gimmickry of all-out advertising. It is easy to be dismayed by all the criticism. But it is nothing new. People throughout history have mocked our calling partly as a way of laughing at life and the fear of death.

Now that medicine is a science, it should be less derided. Yet, we must realize that it will never catch up with all the illusions it can inspire, or live down all the fears it can provoke. Yes, we will be criticized. Still, the public-opinion polls show that we are cherished—moreso than any other calling. I firmly believe that in the dark thinking night of men's souls, we will continue to be cherished, and moreso than ever before.

People will look to us because every advance against sickness and disease is only the prelude to a new challenge. They will look to us because the sorcery of science in artificially creating life, and prolonging it, will cry out to us for answers, ethical and spiritual as well as medical answers. We will be called upon to sit at the bedside of the meaning of life itself.

This federation, with its historic clinical orientation and its expanding ethical concerns, will help us physicians do that, even while it fights the indispensable battles of law and legislation. Throughout this federation, our identify as doctors will endure and expand. So I assume your Presidency with courage for the future. I assume it with reasonable hope. I have moments when hope flickers but I have far more reassurances.

And one of those reassurances comes from a man who was a plantation owner in Old Virginia at a time when smallpox was a scourge. This man was keenly aware of the smallpox vaccine developed by Edward Jenner. He took the lead in introducing it to Virginia and America. He learned how to safeguard the potency of the virus and make innoculations. And as days went by on his plantation and up and down the river and hills, he saw life bloom without the age-old scourge.

Taking time from his duties as President of the United States, he wrote Doctor Jenner a letter that closed with these lines: "You have erased from the calendar of human afflictions one of its greatest. Yours is the comfortable reflection that mankind can never forget that you have lived. Future nations will know by history only that the loathsome smallpox has existed and by you has been extirpated. Accept my fervent wishes for your health and happiness and assurances of the greatest respect and consideration."

Let me be so bold as to suggest that this letter signed "Thomas Jefferson" is a message to all of us. It is an exhortation to all of us "to strive, to seek, to find, and not to yield," to walk tall against the night, and to see, beyond the night, the morning star. It is an affirmation for you and for me particularly in this Bicentennial Year. For this federation, this federation of ours, is the Independence Hall of Medicine. And by the grace of all of you and all of our members, its bell keeps ringing! ■

NEW EMORY REHABILITATION CENTER TO OPEN THIS FALL

The new $7.5 million Emory University Center for Rehabilitation Medicine, a six-story, textured concrete building, will bring a broad range of services in patient care, research, and teaching to Emory's Woodruff Medical Center on campus when the facility is completed and occupied this fall.

The 56-bed center is designed primarily for treatment of adults who have physical disabilities because of problems involving nerve, muscle, bone, heart, and lung functions.

People disabled by stroke or other neurological disease; those who need help in coping with any of the over 100 types of arthritis; victims of cerebral palsy and muscular dystrophy—all these will be helped by the center's sophisticated facilities, equipment, and skilled personnel.

Others who will be aided in regaining as much of their function as possible are patients with spinal cord injuries (an increasing problem among young adults as a result of vehicle accidents), amputees, burn patients, and patients recovering from treatment of cancer.

Also, patients with paralysis, heart and circulation problems, and lung conditions such as emphysema will be provided care so they can realize their full potential for life.

editorials
editorials
editorials

National Health Care for Children and Pregnant Women

A FEW DAYS AGO an announcement was received in the office of the **Journal** from the American Academy of Pediatrics. The press release related how in June of this year the representatives of their organization, appearing before a congressional committee, had whole-heartedly endorsed the concept of a national program of comprehensive health care for all children and pregnant women.

Elsewhere in this issue the full text of their pronouncement is reproduced for your perusal. (See page 348.)

In lieu of editorial opinion and comment to this startling announcement, reader reaction is invited in the form of letters to the editor.

EW

If Jimmy Carter Is President . . .

THE RAPID RISE of Jimmy Carter as a national political force has caused the medical community, both inside and outside Georgia, to ask who he really is. THE answer to this question is hard to find. Having observed him at close range during his term as Governor, read such policy statements as there are, and listened to his national policy and issues director, we are able to determine this: He favors a phased-in national health insurance program, views Medicaid as a national scandal being bilked of millions by charlatans, thinks the malpractice crisis is due to poor quality control and that the country has built a "haphazard, unsound, undirected, inefficient system that has left us unhealthy and unwealthy."

Atlanta attorney Stuart Eisenstat, Carter's national policy and issues director, met with the MAG Executive Committee in August to discuss the candidate's positions on health specifically and campaign themes generally.

Eisenstat said Carter sought an open, responsive and honest government that has efficiency and effectiveness as its watchword. Much of Mr. Eisenstat's discussion centered on issues familiar to Georgians—reorganization of agencies, zero based budgeting and greater regulation of special interest lobbyists. Mr. Carter favors a "sunset" law whereby agencies would automatically expire at the end of five years unless legislation was specifically passed to extend them.

Phased-In NHI

According to Eisenstat, Governor Carter thinks that too much emphasis has been placed on the issue of national health insurance since it is only one component of the health care system. Carter wants to see a phased-in program of NHI with physicians maintaining their traditional doctor-patient relationship



Stuart Eisenstat (center), Carter's national policy and issues director, meets with Executive Committee to review health care goals of the Presidential candidate.

and the patient "in the initial stages" paying part of the costs of NHI. Eisenstat also suggested that Carter wanted a uniform payment system to relieve regional inequities. He also is considering faster payoffs of medical school expenses in return for service in underserved areas of the country, but there would be no mandated service in a specific area.

Mr. Carter wishes to see greater use made of paraprofessional personnel in underserved areas as a method of providing greater access to health care. Coupled with this would be the placing of greater emphasis on preventive medicine which would be part of the NHI proposal.

On the issue of utilization and quality of services, Carter has said that overhospitalization is another cause of national concern and results frequently from insurance policy payments being limited to inpatient care. Mr. Carter has stated that the public should be protected by standards of competence. In his view, Professional Standards Review Organizations offer a "potentially important initiative to monitor the quality of medical care."

Policy and issues director Eisenstat said Carter wanted input from organized medicine on health issues and thought organized medicine should want to be involved, particularly the AMA. When Eisenstat was asked if Carter's opinion of organized medicine had changed from statements made in opposition during 1973 and 1974, Mr. Eisenstat said, "I think it is fair to say he has no love lost for the AMA."

Health Planning Act of 1974 Has Destructive Potential

(Ed. note: Prepared by the Public Affairs Division of the American Medical Association.)

WE PHYSICIANS CAN BE so absorbed by our day-to-day problems that we overlook a gigantic danger now building up—a danger that could compound many of our problems and create new ones.

It's the Health Planning Act of 1974. This law is not just another governmental abstraction. It's not just a sauced-up rehash of Comprehensive Health Planning, the Regional Medical Program, and so forth.

Quite to the contrary, it's the framework for a bureaucratic totalitarianism that could reshape the health-care system as we know it—including the responsibilities and expandability of hospitals and other facilities and even the rates they charge.

Moves to put doctors' offices and fees within the scope of the act are afoot in the Department of Health, Education, and Welfare, even though the AMA got them excluded from the law.

Broad Powers

Certainly there must be planning. And certainly we must avoid costly overbuilding and overstocking of hospitals. Consider some of the ways, however, in which the Health Planning Act would flout the principles of rational planning, be a heavy expense in itself, and imperil the quality of care.

- The Secretary of HEW is to dominate five somewhat overlapping levels of federal, state and local authority. He is also to issue national health planning policy; appoint a national advisory council; approve state and local planning agencies and the funds they receive, and establish the criteria and procedures they use.

- Certificate-of-need legislation must be adopted in all states, as prescribed by the HEW Secretary. The need for all new institutional facilities and services must be certified; the need for all existent institutional services must be reviewed every five years. Practice-profile data from PSROs, plus the minority status of direct providers of care on local planning boards, could arbitrarily influence the expansion or continuation of services.

- Up to six states are to get federal grants to demonstrate rate regulation for health services. This could become mandatory for all states and encompass physicians, if various planners get their way. The result of regulation is likely to be an obsession with cost at the expense of high-quality care.

The AMA has petitioned federal court to join the State of North Carolina in a suit aimed at voiding the law. But adjudication can take many months. Meanwhile, physicians in many parts of the country are seeking adequate representation on local planning boards, showing up at public hearings pursuant to the law, and otherwise fighting the great potential danger. For the moment there is no other game in town.

LETTER TO THE EDITOR

Dear Sir:

In my original final report on the participation of the Medical College of Georgia in the AMA Medical School Project, I included a list of all those who served as consultants to the Department of Obstetrics and Gynecology, University of Saigon. Somehow this was omitted from the published account (JMAG 65:318, August, 1976). In addition to those mentioned in the article, the following individuals made valuable contributions:

Virginia Zachert, Ph.D., research professor, MCG; Carol G. Reznicheck, R.N., consultant in maternal and child health nursing; John D. Thompson, M.D., chairman, Emory; William F. Mengert, M.D., former chairman, Univ. of Illinois; Charles J. Collins, M.D., Orlando, Fla.; George H. Nelson, Ph.D., M.D., chief, Fetal Medicine, MCG; William M. Lester, M.D., associate clinical professor, Emory; Chester B. Martin, M.D., professor, Univ. of Southern California.

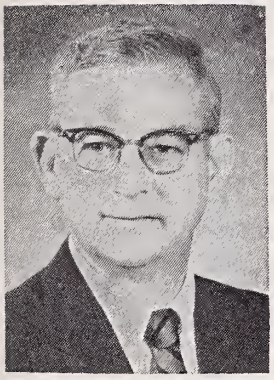
Paul G. McDonough, M.D., chief, Reproductive Endocrinology, MCG; Harry Brody, M.D., chairman, Univ. of Calgary; Ta-Jung Lin, M.D., professor, MCG (two tours); Su-Chin Lin, M.D., research assistant, MCG; Gordon W. Jackson, M.D., Macon; Frederick W. Hanson, M.D., assistant professor, Univ. of California, Davis.

I should also say that a number of other medical schools participated as counterpart departments in other specialties.

Sincerely,
C. I. Bryans, Jr., M.D.
Professor and Vice Chairman
Dept. of Ob-Gyn
Medical College of Georgia

president's letter

MAGNET Conference Planned for You



THIS YEAR'S MAGNET CONFERENCE has been scheduled for October 23 and 24 at the Hotel Sonesta. How does one judge a conference to be successful?

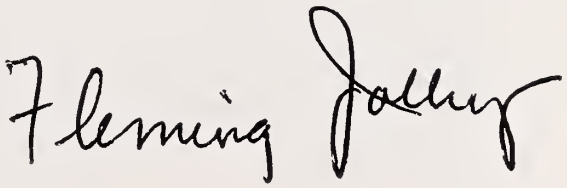
In this issue is the program. It has been planned for you and your office staff. Arrangements are included whereby you experts may help those who are perhaps less efficient.

Maintaining a happy boss is a full time job just as much as delivery of excellence in quality of patient care is.

This MAGNET Conference can be a meaningful experience and I urge your attendance.

In another matter of interest this month, September 16 is the date set by Judge O'Kelley for the formal hearing of the MAG Medicaid suit. Much effort by many people has been given. One can foresee the liklihood of an appeal to higher courts with the decision that is given.

Although collectively MAG speaks for the majority of physicians in Georgia, it does not represent all physicians. Encourage our non-member colleagues to join. We need their support, too.



Fleming L. Jolley, M.D.
President, Medical Association of Georgia

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Statement on Guidelines for Mammography

From the National Cancer Institute and the American Cancer Society

ROBERT L. BROWN, M.D., *Atlanta**

THE FOLLOWING STATEMENT on Guidelines for Mammography has been received by the Breast Cancer Detection Demonstration Project at Emory and Georgia Baptist Hospitals from the National Cancer Institute and the National American Cancer Society. This clarifies the position of these organizations on a matter which has been of concern to all women and their physicians.

"The purpose of the Breast Cancer Detection Demonstration Project (BCDDP) was to demonstrate the ability to recruit, screen, and follow a population of 270,000 asymptomatic women for the early detection of breast cancer. Screening procedures included history, physical exam, mammography and thermography in all women. The original purpose of recruitment and initial evaluation has been accomplished and has resulted in the detection of many breast cancers.

"The value of mammography in totally asymptomatic women under the age of 50 has been questioned. The value of mammography for screening in women over the age of 50 years seems established. There is no question as to the value of mammography as part of the diagnostic workup for symptomatic women of any age. The American Cancer Society and the National Cancer Institute believe that guidance for a course of action is needed until all final reports are submitted to NCI and have been evaluated by the NCI.

"The Director of the National Cancer Institute and the President of the American Cancer Society concur with the following guidelines:

"1. For women of any age in which there is a suspected breast neoplasm, mammography is an accepted part of the complete diagnostic workup.

"2. For asymptomatic women over 50, definite benefit from adding mammography to physical examination has been demonstrated. Mammography is indicated as part of a regular screening program.

"3. For asymptomatic women ages 35-50 years, the sophisticated type of mammography currently available has not been in common use long enough to demonstrate its benefit in reducing mortality in the screened population. It is by no means clear that there is no benefit. In younger women with evidence of being at special risk of breast cancer, the techniques employed may have value in detecting early breast cancer.

"4. The possible risk of inducing a breast neoplasm by the mammographic procedure itself is assumed, but for any individual woman is very small, e.g., as stated by Dr. Upton '. . . a single mammographic examination

* Chairman of the Executive Committee of the American Cancer Society, Georgia Division, Inc. Dr. Brown's address is 1645 Tully Circle, Suite 126, Atlanta, Ga. 30329.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

with the newer low-dose technique, which involves a dose of one rad or less, would be expected to increase a woman's lifetime risk by no more than one percent. Hence, since the risk from natural causes that the average woman will develop breast cancer during her lifetime is roughly one in 15, or seven percent, a single mammographic examination might increase her lifetime risk from 0.07 to 0.0707; by the same token, it would take 100 examinations to double her lifetime risk—that is, to raise it to 0.14. Because the incremental risk per examination is small relative to the individual's lifetime risk from natural causes, a woman should not be reluctant to have a mammogram if there are medical or psychological grounds for desiring the information it could provide. On the other hand, although the presumptive risk to a single individual may be small, the total risk to a large population of healthy women might not be justified unless outweighed by the expectation of a commensurate benefit.'

"5. Thus, the following interim guidelines are prudent. We cannot recommend the routine use of mammography in screening asymptomatic women ages 35-50 years in the NCI/ACS BCDDP at this time. However, in the face of a very small presumed risk for any individual woman, we do not recommend withholding mammography from a woman age 35-50 years if she and the physician agree that it is in her best immediate interest.

"6. For women at high risk because of family history, reproductive history, prior breast cancer, or tumor, etc., the benefits as well as the possible risk of x-ray mammography should be fully explained to the woman concerned and the final decision made between her and the physician.

"7. As with any x-ray examination, radiation dosage must be kept to the lowest dose consistent with good image quality. All screening participants should be informed that the x-ray equipment in the BCDDP program is regularly monitored to determine the radiation exposure levels and these levels are reviewed by experts in radiation physics.

"8. Women of any age who decline mammography should be encouraged to continue in the screening program for history, physical examination, and thermography.

"9. Regardless of the final recommendations, there is no intention to close or phase out the BCDDP's. It is also to be noted that the screening program could be modified in the future in the event of development of new scientific information.

"These are interim guidelines. There may also be a risk in depriving asymptomatic women under the age of 50 of potential benefit to them as individuals. On the other hand, given the possibility of even low risk to large numbers of such women, we feel that the above guidelines are most prudent until such time as additional current data can be analyzed further." ■

heart page
heart page
heart page

Atherosclerosis

A PUBLIC HEALTH PROBLEM

WILLIAM B. STRONG, M.D., *Augusta**

ATHEROSCLEROSIS IS A PROGRESSIVE pathologic process involving the intima of the arteries of most organ systems. The coronary arteries, cerebral arteries and the aorta are most affected resulting in myocardial infarction, cerebrovascular accidents and peripheral aneurysms. The incubation period of atherosclerosis is long, probably in the range of 40 to 50 years from its inception in youths to its clinical manifestations in middle to old age. It claims approximately one million Americans each year and accounts for 50 percent of deaths in the United States. Five percent of its victims die when less than 60 years of age and many more are debilitated in their economic prime. Its financial toll is $40 billion annually for the U.S. The magnitude of this disease is so great that it constitutes a *public health problem.*

If the causes of atherosclerosis were known, appropriate therapy would not be far behind. Unfortunately, the causes are probably multiple and genetically influenced, and a single cause or cure is unlikely to be found in the near future. Therefore, what can we do about this epidemic disease? Since we know that certain risk factors are undeniably associated with an increased incidence of atherosclerosis, why don't we do something about them? In Richmond County a pilot project has been undertaken to educate school children to the atherosclerosis problem. The project was sponsored by the Georgia Heart Association, the Richmond County Chapter and the Georgia Regional Medical Program. There were both educational and service components to the program, hereafter referred to as Project 66.

Goals of Project 66

Project 66 was developed to educate (1) students in general and (2) individuals at highest risk (children of parents who had a myocardial infarction or stroke prior to age 50) to the risk factors and methods of possible intervention.

The three major risk factors are hypercholesterolemia, hypertension, and smoking. The minor risk factors include obesity, sedentary living habits, psychosocial tension, glucose intolerance and genetic predisposition. Let's dispose of the genetic predisposition first. We can't do anything about it at this time so let's just forget it and get on with things about which we can do something.

Fifty percent of the United States population is going to be affected by atherosclerosis. Since we cannot force our citizens to have good health, we can provide everyone with the information and let them make their own decisions. We as physicians are responsible for making our patients aware of the problem; but a one-on-one confrontation does not appear to be the most efficient means to handle the problem. Since we frequently don't have adequate time to provide to each

* Professor of pediatrics, director of pediatric cardiology at the Medical College of Georgia, Augusta, Ga. 30902.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

and every family information on proper nutrition, exercise, and the hazards of smoking, mass public education may be more reasonable and efficient.

Public education of our children appears to be the best chance for success with primary prevention of atherosclerosis. If we can get to the children before their life-long nutritional, activity, and smoking patterns are established, we have a better chance of changing these patterns. An additional reason to aim education at children is the fact that the disease process has not become irreversible. The fatty streaks of an adolescent's coronary arteries are probably reversible whereas the fibrous plaques of a 35-year-old probably are irreversible regardless of the person's motivation to change life-styles.

In the Department of Pediatrics of the Medical College of Georgia, Max D. Miller, Ed.D. and William B. Strong, M.D. developed a slide-tape program for the Georgia Heart Association. The program has both a professional and lay version and deals with atherosclerosis, its natural history, the risk factors and what individuals might be able to do to prevent or delay its consequences. In 1975, we went to the Richmond County Board of Education and requested time in the curriculum of middle grade students. Mr. Oellrich, Chairman of the Board, gave us three hours in the curriculum of these students. In October, 1975, a one-half day program was presented to school nurses and teachers of the following subjects: science, health, physical education, and home economics. These individuals then were responsible for delivering the material to their students. Five of the slide-tape programs were given to the Richmond County Board of Education and distributed from their central supply area to the various middle schools. Six thousand students received instruction. An examination given at the end of the third hour showed an immediate retention of 80 percent of the subject matter. We feel that this type of education is mandatory. If it can be repeated at intervals, possibly every two years, and combined with parent education through PTAs, a significant dent may eventually be made in the prevalence of atherosclerosis.

Information, Then Reinforcement

The atherosclerosis program will not, of itself, suffice. A great deal of re-thinking of school curricula must be done. Children must be given more up-to-date nutritional information. This information should be reinforced by providing nutritionally sound lunches and removing inadequate nutrition from candy and soft drink machines which repose on school premises. Nutrition is critical on many levels—the prevention of exogenous intake of cholesterol and saturated fat, the prevention of excessive caloric consumption in order to prevent obesity and its consequences, especially hypertension. Good nutrition can also stress the avoidance of pure simple sugars and the substitution of more complex sugars and fiber products, especially cereals and grains. By teaching the use of condiments other than sodium chloride, some beneficial effects may accrue to the blood pressure. Therefore, nutritional education in classes of health education and home economics can help to reduce the risk factors of hypercholesterolemia, hypertension, obesity and glucose intolerance.

Physical education courses must be redirected to involve all students in games and recreation which will be enjoyable for a lifetime. Since the mother is central in the family, girls must be made cognizant of the joys of physical activity and participate as fully as boys. A family is much more likely to be physically active if both parents participate rather than just the father. Physical activity can reduce the risk factors of hypertension, burn off excess calories to prevent obesity, and increase cardiovascular tone to decrease the toll of sedentary life styles.

The increased incidence of smoking in the adolescent population says that we are not doing a good job with our anti-smoking campaigns. Toward the end of the 60's, we became complacent because smoking in medical meetings was less common. We forgot that we had a new generation of adolescents who were not party to the anti-smoking campaigns of the 60's. This education must be on-going—not

a one shot affair. The public must be educated to know that they are individually responsible for their health and the primary prevention of atherosclerosis.

In summary, we believe that an educational program aimed at youth can eventually reduce the prevalence of atherosclerosis by attacking the major and minor risk factors with comprehensive nutritional, physical education, and anti-smoking advice. ■

NEW HEALTH SYSTEMS AGENCIES IN GEORGIA

Provided below is a list of addresses for Georgia's seven new Health Systems Agencies and their executive directors. The HSAs were created by Public Law 93-641 signed by President Ford January 4, 1975. This law is called the National Health Planning and Resources Development Act of 1974, designed essentially to replace the Regional Medical Programs, Comprehensive Health Planning Program and the Hill-Burton hospital construction program.

The law was created to augment areawide and state planning for health services, manpower, and facilities. On the federal level, The National Council for Health Policy has been established and is composed of 15 members. The states enter into agreements with the Secretary of HEW for the designation of a State Health Planning and Development Agency. This agency is in turn advised by a Statewide Health Coordinating Council with 60 percent of its members appointed by the governor from the state's Health Systems Agencies. Some 200 HSAs have been created across the country on the regional and local levels. The HSAs will be responsible for preparing and implementing plans designed to improve the health of residents in their area and improve the quality of health services.

1. *Georgia-Tennessee Regional Health Commission*
   Clifford F. Anderson, Jr., Executive Director
   Suite 1220, James Building
   738 Broad Street
   Chattanooga, Tennessee 37402
   Telephone: (615) 266-5781

2. *Appalachian Georgia Health Systems Agency, Inc.*
   Charles McJunkin, Executive Director
   P.O. Box 829
   Cartersville, Georgia 30120
   Telephone: (404) 386-2431

3. *North Central Georgia Health Systems Agency, Inc.*
   Robert A. Youngerman, Executive Director
   Suite 700, Kennesaw Life Building
   1447 Peachtree St., N.E.
   Atlanta, Georgia 30309
   Telephone (404) 892-5952

4. *East Central Georgia Health Systems Agency, Inc.*
   William McKettrick, Executive Director
   Georgia Railroad Bank Building, Suite 1114
   Augusta, Georgia 30902
   Telephone: (404) 724-9927

5. *Health Systems Agency of Central Georgia, Inc.*
   Don J. Trantow, Executive Director
   P.O. Box 2305
   1000 Executive Park, East
   Martha Street
   Warner Robins, Georgia 31093
   Telephone: (912) 922-2215

6. *Southwest Georgia Health Systems Agency, Inc.*
   Rudy Moreau, Executive Director
   P.O. Box 4229
   Albany, Georgia 31706
   Telephone: (912) 883-5070

7. *Southeast Georgia Health Systems Agency, Inc.*
   Morris M. Bradley, Executive Director
   P.O. Box 1455
   Brunswick, Georgia 31520
   Telephone: (912) 264-3525

STUDENT NURSES WORK ABROAD

Each summer since 1967, students from Emory's Nell Hodgson Woodruff School of Nursing have worked abroad. Created by students, the Nursing Abroad Program is designed to help improve nursing and communication with different peoples of the world through exchange of ideas and techniques.

To date 36 students have participated in the program in 21 countries. Money for students' air fare and expenses is raised through projects sponsored by the junior nursing class and through donations. Five students are working this summer in India, Jordan, Haiti, the British Virgin Islands and St. Lucia Windward Islands.

Medical Association of Georgia v. David Mathews, et al

ROBERT W. PATRICK *and* THOMAS P. MILLER, *Atlanta**

(Ed. note: On September 9, 1976 the lawsuit discussed below was dismissed in favor of a settlement. Printing schedules prevented the rewriting of the entire article, which was prepared and set in type prior to the settlement. However, the final paragraph has been rewritten to correctly update information on the status of our litigation.)

We felt that it would be advisable to provide a report to you on the status of our litigation involving the Georgia Medicaid Program. This lawsuit arose out of the controversy surrounding promulgation of a Provider Agreement and Manual by the State of Georgia to direct the manner in which physicians participating in the Medicaid Program shall provide medical care to Medicaid patients as well as the amount of compensation they receive for their professional services. The Medical Association voiced the objections of its members regarding this unlawful revision of the Georgia Medicaid Program to State officials. After a series of unfruitful discussions with these officials, the Medical Association felt compelled to file this lawsuit in the Federal District Court on October 9, 1975, in order to protect the interests of its members.

The lawsuit seeks a declaratory judgment to the effect that the Provider Agreement and Manual are in violation of the Social Security Act and federal regulations, and infringe physicians' constitutional rights under the First, Fifth, Ninth and Fourteenth Amendments to the Constitution. It further asks the Court to enjoin the defendants from requiring physicians to practice medicine according to the terms of the Manual, and from requiring that physicians sign and be bound by the Provider Agreement in order to participate in the Medicaid Program. The lawsuit names as defendants the following individuals: Jim Parham, Commissioner of the Department of Human Resources; Sam Thurmond, Director of the Georgia Medicaid Program; and Governor George Busbee. The Secretary of Health, Education and Welfare, David Mathews, has also been made a party to the lawsuit on the grounds that the federal government either unlawfully approved the revised State Plan for the Georgia Medicaid Program, or alternatively, has violated its statutory duty to insure that said Program is administered in a manner substantially complying with federal law.

Allegations in Lawsuit

The lawsuit alleges several causes of action. It alleges that the State of Georgia failed to gain formal approval by the Secretary of HEW of its revised State Plan governing the Georgia Medicaid Program, and that the changes incorporated in said Plan do not meet certain minimum criteria set forth in the Social Security Act. It also asserts that the Manual and Provider Agreement have lowered the standard of medical care and services available to Medicaid recipients. This is because they discourage participation by a sufficient number of physicians in the Georgia Med-

* Prepared at the request of The Medical Association of Georgia. Mr. Patrick is a partner and Mr. Miller is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

icaid Program and require that providers of medical services administer the least expensive treatment to Medicaid recipients whenever a less expensive method of treatment would produce essentially the same medical results, whether or not the least expensive treatment is the best treatment according to the best medical judgment of the treating physician. The lawsuit also contends that the Georgia State Plan does not sufficiently insure that providers of medical services will be compensated for all reasonable charges. Finally, the lawsuit asserts that the Provider Agreement and Manual directly interfere with the physician-patient relationship in that they interfere with the physician's constitutional right to practice medicine according to his best judgment and the patient's constitutional right to be treated according to the best judgment of the physician of his choice.

Procedurally, we sought a hearing on our request for an injunction against enforcement of the Provider Agreement and Manual, which hearing was initially set for Nov. 7, 1975. Judge Richard Freeman indefinitely postponed this hearing in order to consider the issues of whether the case should be assigned to a three-judge Federal Court, and whether this case should be consolidated with a prior lawsuit involving similar issues brought by the Georgia State Medical Association against the same defendants. The cases were consolidated on Dec. 11, 1975, and the consolidated cases were assigned to Judge William O'Kelley, who has presided over the Georgia State Medical Association case since its inception.

The Secretary of HEW filed a motion to dismiss our lawsuit against him on various grounds which we successfully opposed. In an order dated March 26, 1976, the Court ruled that the Provider Agreement and Manual were part of the State Plan for Medicaid and that federal legislation and regulations required the Secretary of Health, Education and Welfare to review these provisions in order to determine whether they compiled with federal law.

Court Date Set

On July 9, 1976, counsel for all parties met in Judge William O'Kelley's chambers at the request of Judge O'Kelley. After Judge O'Kelley outlined the enormous difficulties involved in scheduling a full-scale trial for our lawsuit, it was agreed that the case would be submitted to the Court entirely on a written record of depositions, affidavits and other materials, at which time counsel for all parties would make a brief oral argument before the Court following the submission of written briefs. Judge O'Kelley required that all evidence to be considered by the Court must have been submitted by September 6, 1976. He tentatively set the date of September 16 for oral argument, at which time all issues would be considered. Judge O'Kelley carefully advised us that it might very well take three to four months for him to rule on the case even after all argument is completed.

We proceeded to engage in extensive efforts to discover information concerning the actions taken by both the State and Federal governments in regard to the challenged changes in the State Medicaid Program. While this preparation for trial continued, we simultaneously entered discussions with counsel for the State of Georgia to explore settlement possibilities. After a series of difficult negotiating sessions, an agreement was reached which was approved by all the respective parties on September 9, 1976. In essence, the State agreed to substitute a new "Statement of Participation" in place of the "Provider Agreement" for the current fiscal year. The Statement of Participation affirmatively acknowledges that it cannot be utilized to interfere with a physician's practice of medicine. It will serve only to govern the general terms and means of reimbursement by the State for individual claims which physicians elect to submit for medical services covered by Medicaid. In return for our agreement to dismiss the lawsuit without prejudice, the State further agreed to meet with representatives of the Medical Association of Georgia within 30 days to discuss and draft joint recommendations to the Board of Human Resources for proposed changes in the present policies and procedures manual for physician services. ■

I've told this before . . . .

(Ed. note: Dr. Eldridge again offers a story, with this reminiscent anecdote from World War II. Others wishing to contribute to this feature page should send their material to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Olive Drab

When I went to France in October 1944 with the 172nd General Hospital, in addition to my other duties, I was assigned as officers' and nurses' club chief. This meant supplying whatever material needs arose!

On departure from the U.S.A., *all* personnel were issued olive drab clothing including bra and pants for female personnel. When the Rhine had been passed and Germany was obviously unable to recover, the women in our units commenced to clamor for more appropriate color in their undergarments!

Forthwith, we received permission to allow their request for lighter colored materials and such was ordered. After several days when our order did not arrive, a tracer was sent out. The order had been shipped according to the supply section in the United Kingdom, but just where the boxes were remained a mystery until some two months had passed. We received a call from a supply unit near Paris, some 150 miles from our station that they had found our order amongst kitchen and mess supplies, and properly labelled according to Army criteria, *small, medium and large cups*. The manifest inside the boxes were labelled pants, slips and brassieres.

F. G. Eldridge, M.D.
Radiological Associates of Valdosta
Suite 104, Doctors Building
Valdosta, Georgia 37601

the association
the association
the association

NEW MEMBERS

Acton, William C., Bibb—Act—R
Box 6273, N. Augusta, South Carolina 29841

Bailey, Ann A., Meri.-Har.-Tal.—A
Ga. Warm Springs Hosp., Warm Springs 31830

Bihl, John H., Thomas Area—Act—I
950 Fourth St., S.E., Cairo 31728

Erdogan, Oran, Cobb—Act—C
1678 Mulkey Road, Suite C, Austell 30001

Gatewood, T. Schley, Jr., Sumter—Act—ObG
205 S. Lee St., Americus 31709

Hayes, T. William, Tift—Act—Oto
222 N. Park Ave., Tifton 31794

Henry, Waights G., III, Cobb—Act—Su
805 Campbell Hill St., Marietta 30060

Kirsh, Alan D., Bibb—Act—R
752 Hemlock St., Macon 31201

Liebman, Paul H., Clayton-Fayette—Act—I
33 S.W. Upper Riverdale Road, Suite 121
Riverdale 30274

Mallari, Raymundo T., Clayton-Fayette—Act—I
33 S.W. Upper Riverdale Road, Suite 121
Riverdale 30274

May, Charles B., Bibb—Act—ObG
380 Hospital Dr., Macon 31201

Nicol, Charles F., MAA—Act—N
340 Boulevard, N.E., Atlanta 30312

Serene, James A., MAA—A
2866 Marlin Dr., Chamblee 30341

Welliver, Gary, Cobb—Act—FP
2480 Windy Hill Road, Marietta 30060

Wherry, Richard A., Bibb—I&R—FP
777 Hemlock St., Macon 31201

Wickliffe, Charles W., MAA—Act—C
1220 E. Rocksprings Road, Atlanta 30306

SOCIETIES

The **Bibb County Medical Society** held its annual old fashioned picnic August 5 with senators and representatives from the area as guests, as well as candidates for national and state offices.

Several **Cobb County Medical Society** members helped give physicals to Cobb County high school athletes in late July. The project was organized by Stephen Bethea, chairman of the Athletic Committee.

Cong. Andrew Young was the guest speaker for the August meeting of the **DeKalb Medical Society.** In addition, the society held a day-long outing at Lake Lanier Islands August 28 with the Auxiliary. The Society plans to establish a DeKalb Health Care Advisory Committee composed of members of the lay community who will be asked to give their opinions on matters of health and health care.

PERSONALS

Second District

Gordon Davis of Sylvester has been appointed to the Governor's Joint Advisory Board of Family Practice, designed to help determine the special areas in Georgia which have the greatest need for family physicians. Others on the committee include **David Sowell** of Atlanta from the Fifth District; **Wells Riley** of Jonesboro from the Sixth District; **James Dismukes** of Adel from the Eighth District; **T. Eugene Kennedy** of Buford from the Ninth; and **Jon Calvert** of Augusta from the Tenth District.

Fourth District

John S. Douglas, Jr. has co-authored a monograph on coronary artery disease published in a series called "Current Problems in Cardiology." The other authors are **Drs. Bruce Logue** and **Spencer B. King** of Atlanta.

Fifth District

Herbert W. Alperin, M.D. has been appointed chairman of the Department of Pediatrics for Georgia Baptist Medical Center.

Seventh District

Medical staff officers at the following hospitals have been elected from among Cobb County physicians for 1976-77: Cobb General—**Gonzalez Camblor,** president **David Markle,** vice president; **Joseph Gardner,** secretary; Smyrna—**Carlos Selmonosky,** president; **William Patterson,** vice president and **Robert Kushner,** secretary; Kennestone—**George Mims,** president, **Evans Nichols,** vice president and **Edgar Vaughan,** secretary.

At the annual meeting of the Cobb County Heart Unit, **Jerome Blumenthal, Luther Fortson** and **Evan Weisman** were honored for Community Service.

Tenth District

V. P. McNamara and **R. B. Greenblatt** of the Medical College of Georgia have prepared a chapter titled "Endocrinology of Human Sexuality" for a publication, *The Sexual Experience*, published in Baltimore.

J. W. Bennett has been named chairman of the Geor-

gia Chapter of the American Academy of Pediatrics for a three-year term.

W. B. Strong was a recent guest lecturer at the Children's Medical Center in Dallas, University of Virginia and Texas Health Sciences Center in Dallas.

DEATHS

Mercer Blanchard

Mercer Blanchard, 88, of Columbus, who retired from practice only a year ago, died August 14. Dr. Blanchard was active as a school physician for many years since his first appointment to that position in 1919, and organized the Department of Pediatrics in The Medical Center. Blanchard Elementary School was named in his honor.

Dr. Blanchard was graduated from the University of Virginia Medical School in 1913, interning at Bellevue and New York Nursery and Child's hospitals. He served in a medical unit attached to the French Army in World War I, then entered the U.S. Army after this country entered the war.

He was a member of the Southern Medical Association and the American Academy of Pediatrics and Trinity Episcopal Church. He was a former Rotarian.

He is survived by his son, Dr. Mercer Carter Blanchard; sister, Mrs. Hayward Douglas Luckett; and two stepdaughters, Katherine Neill McDuffie and Mrs. James Kyle Spencer of Columbus; four granddaughters and two great-grandchildren.

J. C. Morgan, Sr.

James C. Morgan, Sr. of West Point died July 27 at the age of 91. He was born in Dudleyville, Alabama and was graduated from the University of Alabama Medical School. He began practice in 1915 in Fairfax. Dr. Morgan served in World War I, was a lifetime deacon of West Point First Baptist Church and was a charter member of the West Point Lions Club. He received a 50-year pin from the Medical Association of Georgia in 1965.

Survivors include his widow, Mrs. Kate Acree Morgan; daughter, Mrs. Joe L. Lanier, Jr.; sons, Dr. James C. Morgan, Jr. and Dr. John A. Morgan of West Point; four grandchildren and two great-grandchildren.

William Jackson Smith

Brunswick anesthesiologist William Jackson Smith, 55, died July 21. He was a member of the American Society of Anesthesiologists and a deacon in the First Baptist Church of Brunswick.

He is survived by his widow, Mrs. Eldred D. Smith of Brunswick; sons, William Jackson, Jr. and John Kenneth Smith of Brunswick; mother, Mrs. W. Y. Smith of Waycross; brothers, Warren Y. Smith, Jr. of Jesup and Charles O. Smith of Dallas; three grandchildren.

Opportunities for Continuing Medical Education

DECISION-MAKING IN HEALTH CARE
Oct. 16, 1976
Atlanta, Ga.
Contact: Stephen L. Daniel, Ph.D., (404) 876-7535

FINANCIAL, TAX, AND ESTATE PLANNING FOR PHYSICIANS
Oct. 21-23, 1975
Atlanta, Ga.
Category 1 credit
Contact: Div. of Cont. Ed., Medical College of Georgia, (404) 828-3967

THE 1976 MAGNET CONFERENCE
Oct. 23-24, 1976
Atlanta, Ga.
Contact: Charlie Templeton, MAG, (404) 876-7535

AMERICAN COLLEGE OF CHEST PHYSICIANS
42nd Annual Scientific Assembly
Oct. 24-28, 1976
Atlanta, Ga.
Category 1 credit
Contact: A. Soffer, M.D., 911 Busse Highway, Park Ridge, Ill. 60068

CANCER REGISTRY WORKSHOP
Nov. 3-5, 1976
DeKalb General Hospital, Decatur, Ga.
Sponsored by The Georgia Cancer Registry and The American College of Surgeons for Hospital Tumor Registry personnel
Contact: Patty Winters, Georgia Cancer Registry, MAG, 938 Peachtree Street, N.E., Atlanta, Ga. 30309; (404) 875-5546

SOUTHERN MEDICAL ASSOCIATION
70th Annual Scientific Meeting
Nov. 7-10, 1976
New Orleans, La.
Category 1 credit
Contact: Southern Medical Association, 2601 Highland Ave., Birmingham, Ala. 35205

GEORGIA ACADEMY OF FAMILY PHYSICIANS
Nov. 10-14, 1976
Atlanta, Ga.
Category 1 credit
Contact: Camille Day, (404) 321-7445

INTERSTATE SCIENTIFIC ASSEMBLY
Major Emphasis—Family Practice, Internal Medicine, Ob-Gyn, and Psychiatry
Nov. 15-18, 1976
Atlanta, Ga.
Category 1 credit
Contact: Alton Ochsner, M.D., P.O. Box 1109, Madison, Wisc. 53701

MAG SCIENTIFIC ASSEMBLY
Nov. 19-20, 1976
Atlanta, Ga.
Contact: Stephen L. Daniel, Ph.D., (404) 876-7535

CON-ED '76, ALBANY
Recertification seminar approved for credit by the Georgia Dept. of Human Resources
Nov. 19-21, 1976
Albany, Ga.
Contact: C. B. Gillespie, M.D., Course Director, 810 14th Ave., Albany, Ga. 31701

INFORMATION AND REFERRAL SERVICE OPENS ON PARKINSON DISEASE

The American Parkinson Disease Association is opening an information service in Atlanta, at 25 Prescott Street, on October 1, 1976. According to Dr. John Lee, the medical director, "This is to be an information and referral service only. No patient care will be given by our staff. The purpose of this service is to provide information to the public about the disease, its treatment, and where to obtain medical help, equipment for the home, and outpatient physical therapy services. The American Parkinson Disease Association feels that there is a very real need for this information among the general public. Through providing such a service the APDA expects to stimulate public interest in Parkinson's Disease and thereby broaden its financial support for research."

Letters of explanation are being sent to MAG members most likely to be diagnosing and treating Parkinsonians (family physicians, internists, and neurologists) with an eye toward forming a referral list for the entire state for Parkinsonians and, eventually, establishing a reporting and recording procedure to enable the APDA to gather epidemological data on Parkinsonism in this area of the country.

Persons desiring more information may call 892-6995, or write to: The Parkinson's Disease Information Service, 25 Prescott St., Atlanta, Ga. 30308.

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John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

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ACCREDITED BY THE J. C. A. H.

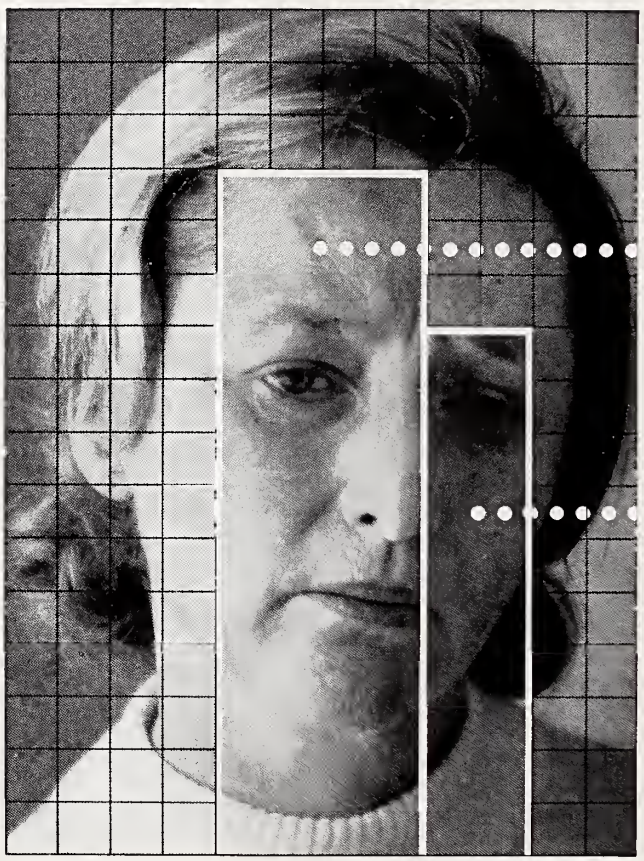
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequ and/or severity of grand mal seizures require increased dosage of standard convulsant medication; abrupt withdr may be associated with temporary increase in frequency and/or severity o seizures. Advise against simultaneous gestion of alcohol and other CNS depr sants. Withdrawal symptoms (similar those with barbiturates and alcohol) h occurred following abrupt discontinu (convulsions, tremor, abdominal and cle cramps, vomiting and sweating). addiction-prone individuals under car

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THE COVER

The beautiful Omni International Hotel, part of the Omni complex which now includes a convention center, sports arena, office building, shops and recreation center, is the site of the 1976 Scientific Assembly. Cover by Atlanta artist Bob Hamill.


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JOURNAL
of the medical association of
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MAG Annual Scientific Assembly

NOVEMBER 19-20, 1976 • OMNI INTERNATIONAL HOTEL • ATLANTA

Last year's Scientific Assembly was an important milestone—MAG's first scientific meeting held independently from the annual spring business session. Very few state medical societies have ventured in this direction, and, despite the planning committee's initial trepidation, the idea worked. Over 400 physicians registered for the scientific programs in 10 medical specialties.

This year's Scientific Assembly, to be held November 19-20, promises to be bigger and better. We are expanding to the more spacious quarters of the Omni International Hotel, and four additional specialty groups have made plans to join us: dermatology, nuclear medicine, psychiatry, and public health. Every physician should be able to find continuing education sessions directly relevant to his or her practice.

Varied Activities

The format for the 1976 Assembly will be the same as last year's: simultaneous scientific programs on Friday and Saturday, a MAG-sponsored luncheon for physicians and their spouses on Friday, medical school alumni receptions on Friday evening, and a special educational program for spouses. The Omni complex will provide plenty of opportunities for extracurricular activities, including dining, shopping, ice skating, professional basketball and hockey, and a family entertainment treat called the World of Sid and Marty Krofft.

The Friday luncheon will feature the annual Abner W. Calhoun Lecture. In the fine tradition of previous years, our 1976 lecturer will be the distinguished Jack D. Myers, M.D., of the University of Pittsburgh School of Medicine, who is president of the American College of Physicians.

On Saturday the Georgia Society of Internal Medicine will sponsor a luncheon. Guest speaker will be Thomas R. Harris, M.D., Shelby, North Carolina, a trustee of the American Society of Internal Medicine.

Spouses' Program

The spouses' educational program on Friday afternoon has been carefully planned to focus on the subject of the home. Catherine Frangiamore, curator of the Atlanta Historical Society and author of several books, will give a slide lecture entitled "The Fashionable Interior: 19th Century Furnishing Styles in America." Many of the examples will be from Southern homes. In addition, Anselm Atkins, an Atlanta artist who spent 15 years at the Trappist Monastery in Conyers, will give a presentation on his specialty—the aesthetics of stained glass windows.

We at the MAG are excited about the plans for the 1976 Scientific Assembly. We think you will be too. Plan now to attend, and don't forget to include your spouse and family. They'll enjoy the Omni just as much as you will.

Credit Applications

AMA Category 1 credit toward the Physician's Recognition Award and AAFP credits have been applied for all sessions of the Scientific Assembly.

Members of the Planning Committee for the 1976 Scientific Assembly include: James K. Van Buren, M.D., Chairman, Nicholas E. Davies, M.D., LaMar S. McGinnis, M.D., Carter Smith, Jr., M.D., A. Calhoun Witham, M.D. and Stephen L. Daniel, Ph.D., Coordinator.

Appreciation

The following pharmaceutical firms are thanked for contributing grants and speakers funds to the scientific programs: Bristol Laboratories, Ciba Pharmaceutical Company, Eli Lilly and Company, Merck Sharp & Dohme Postgraduate Program, Reed & Carnrick, A. H. Robins Company, Smith Kline & French Laboratories and E. R. Squibb & Sons, Inc. The educational program sponsored by the Georgia Gastroenterologic Society has been funded partially through a grant from Searle Laboratories.

Chronological Schedule

FRIDAY, NOVEMBER 19

9:00 to 12:00 Registration

GEORGIA THORACIC SOCIETY AND AMERICAN COLLEGE OF CHEST PHYSICIANS, GEORGIA CHAPTER

9:00 to 12:00 *Reactive Airways Disease*
William A. Speir, M.D., Chairman
Medical College of Georgia

9:00 to 9:05 Opening Remarks:
Alan Plummer, M.D.
Emory University School of Medicine

9:05 to 9:50 "Immunology and Biochemical Factors"
Stephen I. Wasserman, M.D.
Harvard University Medical School

9:50 to 10:00 Discussion

10:00 to 10:15 Coffee Break

10:15 to 10:45 "Bronchodilator Therapy"
Alan L. Plummer, M.D.

10:45 to 11:05 "Use of Steroids and Intal"
Robert DiBenedetto, M.D.
Medical College of Georgia

11:05 to 11:35 "Immunotherapy"
Stephen I. Wasserman, M.D.

11:35 to 12:00 Panel Discussion
Drs. DiBenedetto, Plummer and Wasserman

12:00 to 2:00 MAG Luncheon for all attending physicians and spouses. 1976 Abner W. Calhoun Lecture: "The Distribution of Training Opportunities in Graduate Medicine," Jack D. Myers, M.D., University of Pittsburgh School of Medicine; President, American College of Physicians.

2:00 to 5:15 *Lung Cancer*
Alan L. Plummer, M.D., Chairman

2:00 to 2:45 "Preoperative Evaluation: Metastatic Work-up: Mediastinoscopy and Other Diagnostic Techniques"
Will Sealy, M.D.
Duke University Medical Center

2:45 to 3:15 "Preoperative Use of Pulmonary Function Tests"
G. Michael Duffell, M.D.
Emory University School of Medicine

3:15 to 3:30 Panel Discussion
Drs. Sealy and Duffell

3:30 to 3:45 Coffee Break

3:45 to 4:10 "Surgical Treatment and Results"
Will Sealy, M.D.

4:10 to 4:35 "Radiotherapy and Results"
Jerry Howington, M.D.
Medical College of Georgia

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, GEORGIA CHAPTER

2:00 to 5:00 "Innovations in Public Health"
John T. Gentry, M.D.
Commissioner of Health, Erie County Health Department, Buffalo, New York

AMERICAN COLLEGE OF PHYSICIANS, GEORGIA CHAPTER

Presiding: Thorne S. Winter, III, M.D., F.A.C.P.
Program Co-Chairman

1:55 to 2:00 *Welcome*
Nicholas E. Davies, M.D., F.A.C.P.
Governor for Georgia

2:00 to 3:00 "The Computer, Artificial Intelligence and Medical Diagnosis"
Jack D. Myers, M.D.

President, American College of Physicians; University of Pittsburgh School of Medicine

3:00 to 3:45 "Hair Today, Gone Tomorrow"
Leslie Rose, M.D.
Hahnemann Medical College, Philadelphia

3:45 to 4:00 Coffee Break

4:00 to 4:45 "A Rationale for Management of Myocardial Infarctions"
Burton E. Sobel, M.D.
Washington University School of Medicine, St. Louis

4:45 to 5:30 "Varient Angina"
William B. Hood, Jr., M.D.
Boston University School of Medicine

4:35 to 5:00 "Chemotherapy and Results"
Daniel W. Nixon, M.D.
Emory University School of Medicine

5:00 to 5:15 Panel Discussion
Drs. Sealy, Howington, and Nixon

AMERICAN COLLEGE OF SURGEONS, GEORGIA CHAPTER

2:00 to 3:30 Presentation of essays by surgical residents in competition.

3:30 to 5:00 Panel Discussion: "Inflammatory Bowel Disease"
William C. McGarity, M.D., Atlanta, Moderator
Richard Amerson, M.D., Atlanta
John Dickinson, M.D., Rome
Harold Engler, M.D., Augusta
William Whitaker, M.D., Atlanta
Frank Wilson, Jr., M.D., Atlanta

GEORGIA NEUROLOGICAL ASSOCIATION

2:00 to 3:00 "Language Disturbances"
D. Frank Benson, M.D.
Boston University School of Medicine

3:30 to 5:00 Business Meeting

GEORGIA RADIOLOGICAL SOCIETY AND GEORGIA GASTROENTEROLOGIC SOCIETY

2:00 to 5:00 *The Biliary Tree*

2:00 to 2:20 "Cholelithiasis: An Overview"
Ted Hersh, M.D.

2:20 to 2:30 "Chemical Dissolution of Gallstones: The National Cooperative Gallstone Project."
Ted Hersh, M.D.

2:30 to 3:15 "The Metabolism of Biliary Contrast Media"
Elliott C. Lasser, M.D.
University of California School of Medicine, San Diego

3:15 to 3:30 Coffee Break

3:30 to 4:00 "Retrograde Endoscopic Cholangiography"
David Zimmon, M.D.
New York University School of Medicine

4:00 to 4:30 "Hyperplastic Cholecystoses"
James V. Rogers, M.D.

4:30 to 4:45 "Ultrasound of the Gallbladder"
Peter Sones, M.D.

4:45 to 5:00 "T-Tube Basket Removal of Gallstones"
Peter Sones, M.D.

5:00 to 5:15 Questions and Answers

GEORGIA SOCIETY OF OPHTHALMOLOGY

2:00 to 2:10 Opening Remarks

2:10 to 2:30 "Carotid Cavernous Fistula, An Unusual Cause of Glaucoma"
John C. Rieser, M.D.

2:30 to 2:50 "Neovascular Glaucoma: Diagnostic and Therapeutic Considerations"
Thomas S. Harbin, Jr., M.D.

2:50 to 3:10 "The Ultrastructure of Cogan-Guery Corneal Dystrophy"
F. P. Calhoun, Jr., M.D.

3:10 to 3:30 "Subretinal Neovascularization Following Traumatic Choroidal Rupture"
Sumner Fishbein, M.D.

3:30 to 4:00 Senator Virginia Shapard, President, North Central Georgia Health Systems Agency

4:00 to 4:20 Coffee Break

4:20 to 4:40 "Five-Year Survival Studies on Our First 71 Cases of Malignant Melanoma Studies with P_{32}"
William H. Jarrett, III, M.D.

4:40 to 5:00 "Ocular Motility Problems in Thyroid Eye Disease"
Zane Pollard, M.D.

GEORGIA SOCIETY OF PLASTIC SURGEONS

2:00 to 4:00 *Difficult Coverage and Reconstruction Problems Treated by Tissue Transfers and Flaps*
"Free Composite Tissue Grafts to Lip"
Edwin C. Pound, Jr., M.D.
"Local and Distant Thumb Flaps"
Theodore C. Whitson, M.D.
"Groin Flaps to Thumb"
John C. Munna, M.D.
"Abdominal Pedicle Flaps"
Joseph M. Still, Jr., M.D.
"Cross Leg Flaps"
Lovic W. Hobby, M.D.
"Decubitus Ulcer Flap Coverage"
Morton Slutsky, M.D.
"Nasal Flap Coverage"
Robert W. Crow, M.D.
"Facial Flaps for the Resurfacing"
Michael B. Feineman, M.D.
"Visor Flaps for the Face"
John M. Griffin, M.D.
"Tubed Delayed Pedicle Flap from Chest to Mouth"
William E. Huger, Jr., M.D.
"Deltopectoral Flaps for Head and Neck Problems"
H. Hutson Carspecken, M.D.
"Forehead Flaps"
Robert P. Leonard, M.D.
"Myocutaneous Facial Flaps"
John H. Hartley, M.D.
"Temporalis Muscle Transfers to Face"
Benjamin H. Wofford, Jr., M.D.
"Omental and Gracillis Muscle Transfers"
John Bostwick, III, M.D.
"Muscle Transfers for Coverage Problems"
Stephen J. Mathes, M.D.
"Experiments with Myocutaneous Flaps"
Foad Nahai, M.D.
"The Latissimus Dorsi Muscle and Skin Flap for Breast Reconstruction"
William Schneider, M.D.
"Free Vascularized Jejunal Graft to Palate"
Paul W. Black, M.D.

4:00 to 4:15 Coffee Break

4:15 to 5:00 "Use of Distant Tissues for Free Grafts Incorporating Microvascular Anastomoses and Micro Nerve Transplants and Reimplantation of Digits"
Robert Acland, M.D.
University of Louisville

SPOUSES PROGRAM

2:30 to 3:30 "The Aesthetics of Stained Glass Windows"
Anselm Atkins, Ph.D.
Atlanta stained glass artist

3:30 to 4:30 "The Fashionable Interior: Nineteenth Century Furnishing Styles in America"
Catherine Frangiamore, Curator
Atlanta Historical Society

Social Events

FRIDAY EVENING

6:00 to 8:00 American College of Physicians and Georgia Society of Internal Medicine
Reception

6:00 to 7:00 Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter
Reception

6:00 to 8:00 Emory University School of Medicine Alumni
Reception

6:00 to 7:30 Medical College of Georgia Alumni
Reception

6:00 to 8:00 Tulane Medical Alumni Association
Reception

7:00 to 9:00 Georgia Society of Plastic Surgeons
Reception and Dinner

SATURDAY

12:00 to 1:30 Georgia Neurosurgical Society
Luncheon

12:00 to 2:00 Georgia Society of Internal Medicine
Luncheon
Speaker: Thomas Reginald Harris, M.D., Shelby, N.C.; Trustee, American Society of Internal Medicine

12:00 to 2:00 Medical College of Georgia Foundation
Luncheon

SATURDAY, NOVEMBER 20

9:00 to 12:00 Registration

AMERICAN COLLEGE OF PHYSICIANS, GEORGIA CHAPTER

Presiding: Warren W. Davis, M.D.
Program Co-Chairman

8:30 to 9:15 "Newer Concepts in Diuretic Therapy"
Juha P. Kokko, M.D.
Southwestern Medical School, University of Texas, Dallas

9:15 to 10:00 "Bone Marrow Transplantation in Man"
Martin J. Cline, M.D.
University of California School of Medicine, San Francisco

10:00 to 10:15 Coffee Break

10:15 to 11:00 "Sites of Acute Airway Responses in Asthma and Modification by Pre-Treatment"
Roland H. Ingram, Jr., M.D.
Harvard Medical School

11:00 to 11:45 "Hepatitis"
John T. Gallambos, M.D.
Emory University School of Medicine

GEORGIA NEUROSURGICAL SOCIETY

8:30 to 9:00 Business Meeting

9:00 to 12:00 *Central Nervous System Infections*
William Chew, M.D.
Medical College of Georgia
Robert McLaurin, M.D.
University of Cincinnati

12:00 to 1:30 *Luncheon.* Papers on Central Nervous System Infections will be presented.

1:30 to 5:30 *Central Nervous System Infections,* Continued
Drs. Chew and McLaurin

GEORGIA PSYCHIATRIC ASSOCIATION

9:00 to 12:00 "Not Guilty by Reason of Insanity"
A brief history of the humanitarian concerns which led to current statutes permitting "not guilty" pleas on grounds of "insanity." A discussion of civil rights of hospitalized psychiatric patients vs. protection of community, and a specific legislative remedy to protect the civil rights of psychiatric patients, yet prevent public threat posed by premature release of these patients.
Panel discussion and open debate by Assistant U.S. Attorney Dorothy Y. Kirkley, W. D. Skelton, M.D. and J. A. Raines, M.D.

GEORGIA RADIOLOGICAL SOCIETY, GEORGIA GASTROENTEROLOGIC SOCIETY and AMERICAN COLLEGE OF SURGEONS, GEORGIA CHAPTER

8:30 to 1:00 *The Biliary Tree*

8:30 to 9:15 "Reactions to Contrast Media"
Elliott C. Lasser, M.D.

9:15 to 9:45 "Percutaneous Cholangiography"
Rex Teeslink, M.D.

9:45 to 10:00 "Combined Angiography and Cholangiography in Common Duct Obstructions"
Martin Goldman, M.D.

10:00 to 10:15 Coffee Break

10:15 to 10:45 "Endoscopic Retrograde Removal of Biliary Stones"
David Zimmon, M.D.

10:45 to 11:15 "The Surgical Approach to Cholelithiasis"
John P. Wilson, M.D.

11:15 to 12:00 Panel Discussion
Moderator: Julius Wenger, M.D.
Panel: Drs. Goldman, Lasser, Teeslink, Wilson, Zimmon

12:00 to 1:00 Business Meeting, The Georgia Radiological Society

GEORGIA SOCIETY OF OPHTHALMOLOGY

9:00 to 9:20 "Treatment of Dysthyroid Exophthalmos"
Clinton D. McCord, M.D.

9:20 to 9:40 "Pathogenesis and Treatment of Recurrent Corneal Erosions"
H. Dwight Cavanagh, M.D.

9:40 to 10:00 "The Treatment of Ocular Histoplasmosis"
Frank C. Bell, M.D.

10:00 to 10:20 "Diffuse Infiltrating Retinoblastoma"
Fleetwood Maddox, M.D.

10:20 to 10:30 Question and Answer Session

10:30 to 11:15 Lt. Governor Zell Miller

11:15 to 11:45 Coffee Break

11:45 to 12:05 "Seldom Appreciated Diagnostic Techniques"
Alvin W. North, M.D.

12:05 to 12:25 "VIRA-A and Vidarabine 5′ Phosphate in the Treatment of Herpes Simplex Keratitis"
David S. Hull, M.D.

12:25 to 12:45 "Intraocular Foreign Bodies"
William S. Hagler, M.D.

12:45 to 1:05 "Cystoid Macula Edema Following Intracapsular, Extracapsular, and Lens Implantation Surgery"
P. Thomas Manchester, Jr., M.D.
William S. Hagler, M.D.

12:00 to 1:30 Georgia Neurosurgical Society Luncheon

12:00 to 2:00 Georgia Society of Internal Medicine Luncheon
Speaker: Thomas Reginald Harris, M.D., Shelby, N.C., Trustee, American Society of Internal Medicine

12:00 to 2:00 Medical College of Georgia Foundation Luncheon

GEORGIA SOCIETY OF DERMATOLOGISTS and the ATLANTA DERMATOLOGICAL ASSOCIATION

2:00 to 2:45 "The Dermatologist as a Clinical Investigator"
Harold O. Perry, M.D.
Mayo Clinic, Rochester, Minn.

2:45 to 2:55 Questions

2:55 to 3:15 "The Endocrine Evaluation of Hirsutism"
John R. K. Preedy, M.D.
Emory University School of Medicine

3:15 to 3:20 Questions

3:20 to 3:40 "Recent Advances in Immunology"
David S. Gordon, M.D.
National Center for Disease Control, Atlanta

3:40 to 3:45 Questions

3:45 to 4:05 "Pathophysiology of the Delayed Skin Test"
Donald C. Abele, M.D.
Medical College of Georgia

4:05 to 4:10 Questions

4:15 to 5:30 Business Meeting. Edward Smith, M.D., Presiding

GEORGIA SOCIETY OF NUCLEAR MEDICINE

1:30 to 4:30 "Studies of the Biliary System Using ^{99m}Tc-HIDA: Application in the Differential Diagnosis of Jaundice"
"Non-transaxial Tomography Using the Anger Scanning Camera in Studies of the Liver and Pancreas"
Malcolm Cooper, M.D.
The University of Chicago

REGISTRATION FORM

1976 MAG Scientific Assembly

November 19-20 • Omni International Hotel • Atlanta

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- ☐ Georgia Neurosurgical Society
- ☐ Georgia Psychiatric Association
- ☐ Georgia Radiological Society and Georgia Gastroenterologic Society
- ☐ Georgia Society of Dermatologists and Atlanta Dermatological Association
- ☐ Georgia Society of Nuclear Medicine
- ☐ Georgia Society of Ophthalmology
- ☐ Georgia Society of Plastic Surgery
- ☐ Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter

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Many patients who had not responded to other antihypertensive drugs experienced good blood pressure control with this agent.

Effective Blood Pressure Reduction And Diuresis With Metolazone

FRED O. KESSLER, M.D., F.A.A.F.P., *Savannah**

METOLAZONE† IS A NEW diuretic/antihypertensive agent which is structurally related to quinethazone. Although it too is a sulfonamide derivative, recent studies in humans and animals have shown that metolazone differs from the thiazides qualitatively as well as quantitatively.

Metolazone and chlorothiazide inhibit sodium reabsorption by different mechanisms.[1] Metolazone has been shown to exert its effects in both the proximal tubule and the cortical diluting segment of the distal nephron.[2] Chlorothiazide inhibits carbonic anhydrase activity and metolazone does not.[3] In healthy volunteers, Steinmuller and Puschett[3] reported a much greater rate of potassium excretion for chlorothiazide and a more prolonged diuretic effect for metolazone. Other investigators have reported favorably on the clinical diuretic[4–6] and antihypertensive[7–9] effects of the drug.

The apparent successful experience with metolazone thus far served as the motivation for us to assess it on a trial basis in patients who either were not satisfactorily controlled by other drugs or had not been treated before but appeared to be candidates for such therapy. The drug's antihypertensive activity was our major interest.

Methods

For three months we maintained a monitoring system for all patients who were then receiving metolazone. New patients given metolazone during that period were started on the drug according to the same criteria which had been applied before our decision to publish this experience, namely that, for hypertension, metolazone was prescribed for any patient who might otherwise have been given a thiazide and for edematous patients, the drug was used instead of furosemide wherever possible. This procedure was maintained so that the integrity of the private practice setting, established for this review, would not be compromised. After this period, the data from the records pulled and monitored during that time were compiled and analyzed.

Description of Patients

A total of 30 patients had received metolazone during the course of their treatment. The drug was prescribed for 19, primarily for the purpose of lowering their blood pressure, and to the other 11 for relief of edema. One patient who received two separate courses of metolazone for hypertension was counted twice for statistical purposes. Four of the hypertensive patients also had edema.

The average age of both the edematous and hypertensive patients was 52 years. The youngest was 21 years old and the oldest 77. There were 21 females and 9 males, 25 white and 5 black.

None of the hypertensive patients had demonstrable pathology that could account for the increased blood pressure. Thus, by our standards, these patients generally had mild to moderate essential hypertension, that is, systolic pressure between 140 and 200 mmHg and/or diastolic pressure between 95 and 115 mmHg. (Two patients, M. H. and L. P., had pressures slightly in excess of these levels, but were nevertheless considered to be good candidates for metolazone therapy because of poor response to other drugs in the first case and accompanying edema in the second.) Each patient's pertinent characteristics are given in Table 1.

The mean pressure in these patients prior to initiation of metolazone was 169/101 mmHg. A few patients were newly diagnosed as hypertensive, but most had had elevated blood pressure for years and had been treated with various antihypertensive drugs, singly and in many combinations. Spironolactone or methyldopa, either alone or with hydrochlorothiazide, were the drugs used most frequently in these patients. In many cases these drugs were effective initially,

* Dr. Kessler is a Diplomate of the American Board of Family Practice. Address requests for reprints to 3802 Waters Ave., Savannah, Ga. 31404.

† Zaroxolyn®, trade name of the Pharmaceutical Division, Pennwalt Corporation, Rochester, New York.

but response to them often seemed to diminish after a few months.

Most patients were moderately to severely obese, with an average weight of 197 lb. at start of treatment and a long history of little or inconsistent response to various regimens of appetite suppressants, hormone adjustments, dietary restrictions, and exercise programs.

In the other 11 patients, 9 women and 2 men, edema was due to impaired renal excretion caused by congestive heart failure, other cardiac pathology, or peripheral circulatory disturbance. In one patient the edema probably was the result of prolonged use of oral contraceptives. With the exception of the latter patient, all of the women and one of the two men were moderately to severely obese, with an average weight of just under 160 lb.

Observations

For the 19 hypertensive patients, metolazone most commonly was prescribed in a dosage of one 5 mg tablet once a day. Three patients had their dosage increased to 10 mg a day for added effect, one patient had his dosage cut in half temporarily because of side effects, and another was put on a 5 mg every-other-day schedule because she claimed the drug interfered with her sleep. At the time of the data review, the average duration of metolazone treatment was 9 weeks, the maximum 34 weeks and the minimum 1 week.

Mean blood pressure of these patients fell from 169/101 mmHg to 148/90 mmHg, a mean decrease of 21/11 mmHg (Figure 1). We considered the response impressive in at least 14 of the 19 patients,

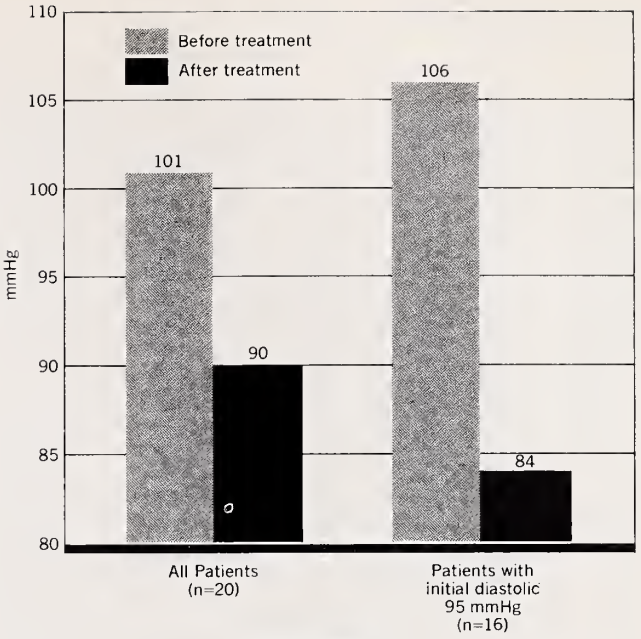


FIGURE 1
Response of diastolic blood pressure to metolazone.

both in the context of our evaluation of antihypertensive therapy generally and the history of many of these patients specifically.

Very large reductions were observed in some patients who had not, to our knowledge, received prior drug therapy for hypertension: J. A., a 40-year-old female who was given metolazone 5mg a day for almost three weeks without appreciable effect, responded to a doubling of dosage with a reduction of 30/30 mmHg (from 160/110 mmHg to 130/80 mmHg) in nine days—she did not receive any adjunctive antihypertensive or diuretic medication. J. D., a 35-year-old obese man, presented with blood pressure of 172/110 mmHg. Metolazone

TABLE 1
HYPERTENSIVE PATIENTS TREATED WITH METOLAZONE

Patient No.	Age	Sex	Race	Metolazone Dosage (mg)	Therapy Duration (wks)	Blood Pressure (mmHg) Initial	Final	Change
02 (AK)	51	F	W	5-10	6	150/100	138/100	− 12/00
03 (AC)	74	F	W	5	30	150/86	140/90	− 10/+ 4
04 (JM)	55	M	W	5	30	170/100	138/82	− 32/18
07 (HF)	59	M	W	5	34	150/100	152/100	+ 2/00
09 (EF)	66	F	W	5	7	168/80	140/82	− 28/+ 2
11 (HW)	66	M	W	5-10	3	154/100	144/82	− 10/18
12 (CH)	54	F	W	5*	20	168/108	130/90	− 38/18
13 (IY)	43	F	B	5	6	170/94	150/88	− 20/6
16 (EC)	58	F	W	5	8	164/100	140/85	− 24/15
17 (PB)	75	F	B	5	5	180/98	170/70	− 10/28
18 (JA)	40	F	B	5-10	4	160/110	130/80	− 30/30
19 (MH)	38	M	W	5	4	180/114 180/126	170/110 154/110	− 10/4 − 26/16
21 (JD)	35	M	W	2.5-5	4	172/110	130/80	− 42/30
22 (LP)	56	F	W	5	6	220/110	160/96	− 60/14
25 (HK)	53	F	W	5	2	170/100	164/90	− 6/10
26 (AY)	57	M	B	5	1.5	164/106	138/80	− 26/26
27 (SA)	24	F	B	5	1.5	180/110	154/94	− 26/16
29 (WH)	51	M	W	5	1	184/80	170/100	− 14/+ 20
30 (MR)	29	F	W	5	8	150/98	146/94	− 4/4

* Decreased to every other day.

was prescribed initially in 5 mg daily dosage; after four days this dosage was reduced by half when the patient complained by telephone of nausea and weakness. The full dosage was restored a few days later when the patient was seen for his first follow-up visit. After a total of three weeks on this and no other therapy, his blood pressure had fallen to 130/80 mmHg and his weight from 206 to 199 lb. There was no further complaint of weakness or nausea.

Among those whose response was less than satisfactory were one patient who had been treated for only one week at the time of data collection, one who had failed to respond previously to spironolactone and a combination of reserpine and chlorothiazide, and another who had not been controlled by any of various thiazide diuretics, furosemide, or guanethidine. A fourth patient with an initial blood pressure of 150/100 mmHg had not been previously treated and responded only marginally to administration of metolazone 5 mg for six weeks. This patient's dosage has since been doubled and evaluation is continuing. The fifth patient had no effect from an initial course of metolazone, which was stopped after only two weeks. When methyldopa also failed to elicit a response and, in fact, was associated with a blood pressure rise from 170/110 mmHg to 180/126 mmHg, metolazone was restarted, and in two weeks the measurement was 154/110 mmHg. This patient should thus actually be considered a responder.

In all, then, encouraging signs of response were seen in 15 of the 19 patients, 70 percent. Moreover, if only the 16 patients with diastolic hypertension ($>$ 95 mmHg) are considered, the mean decrease was 22 mmHg, from an initial mean of 106 mmHg to 84 mmHg after metolazone treatment for a mean duration of nine weeks (Figure 1).

Blood pressure reductions were observed shortly after metolazone was started in most patients. By the first follow-up visit, 5 to 10 days after the initial prescription, the mean blood pressure was 146/92 mmHg, a decline of 23/9 mmHg. Metolazone was added to existing antihypertensive regimens for three patients. Many patients were receiving other drugs during this period, primarily appetite suppressants, hormones, and phenylbutazone for inflammatory conditions.

Most gratifying was the experience with patients whose response to metolazone was in contrast to the negligible effect of previous medications. One patient (P. B.) showed the first real improvement on metolazone, having failed to respond to previous administrations of reserpine and hydrochlorothiazide, methyldopa and hydrochlorothiazide, spironolactone, and acetazolamide. One patient (L. P.) experienced a reduction in blood pressure from 220/110 mmHg to 160/96 mmHg after six weeks treatment with metolazone. She had failed to respond to a previous course of reserpine and hydrochlorothiazide. Simultaneous response of hypertension and edema was observed in the four patients in whom these conditions coexisted.

Nine of the 11 patients who were given metolazone for control of edema responded to the drug. It was stopped after nine days for one patient who complained of weakness and it was ineffective in another patient who also had failed to respond to furosemide. Metolazone was prescribed in doses of 2.5 to 5 mg either daily or prn for as little as 10 days and intermittently, for as long as eight months.

Control of edema was excellent and most patients had accompanying weight loss and improvement of other signs and symptoms, such as pulse, respiration, headache, and shortness of breath. In one patient metolazone successfully relieved edema when added to furosemide, which had not provided sufficient control; appetite suppressants frequently were administered concommitantly. The experience with two patients is particularly vivid, for each had failed to respond to intervals of administration of many other diuretics, including thiazides and furosemide. Metolazone, however, brought about rapid and complete control.

Side Effects

Nine of the 30 patients in this review had complaints which were possibly related to administration of this drug. Weakness or dizziness was the complaint in seven of the nine; in some cases the feeling was prominent, and sufficient to stop treatment in one patient. Otherwise, a temporary reduction in dosage permitted the successful continuation of treatment, usually without further complaint. These reactions, typical of diuretic therapy, were probably indicative of a mild hypokalemia, and potassium supplements were prescribed as necessary. Other complaints in various combinations included vertigo, nocturia, diarrhea, chest pain, nausea, headache, bad taste, and insomnia. With the exception of the one case mentioned, no side effect was severe enough to interfere significantly with therapy.

Comments

Metolazone has now been available for a little more than a year, and controlled studies have shown it to be as effective an antihypertensive agent as chlorthalidone[8] and hydrochlorothiazide.[9] Our data and overall impressions derived from its routine use

in family practice corresponds to that of other authors.

A number of the specific characteristics of the drug are advantageous. Its diuretic effects are less harsh than those of furosemide, for example. It has the convenience of smaller doses and its persistent natriuretic activity, observed at 24 hours after doses of 15 to 50 mg by Materson et al,[10] permits its administration on a once-a-day basis. In most cases its antihypertensive effect was demonstrable within a few days and was pronounced within three to four weeks. This response was generally maintained, or further improved, during continuation of treatment.

In the few instances in which a sufficient response had not been demonstrated after six to eight weeks, methyldopa or spironolactone usually was added. There have been no difficulties encountered in administering metolazone with other diuretics and antihypertensive agents, although naturally we titrate dosage carefully when two or more such drugs are given simultaneously.

As with the thiazide-type diuretics, symptoms of hypokalemia were the most common complaints associated with metolazone administration and, of these, a generalized feeling of weakness was the chief issue. However, this was less of a problem with metolazone than with furosemide, and this condition responded almost always to dosage adjustment and/or potassium supplementation. In this population continuous routine monitoring of electrolytes in every patient was not feasible. However, periodic laboratory determinations for some patients did not indicate any changes of note; there were several clinically insignificant increases in SGOT.

Summary and Conclusions

A retrospective and current review of the records of all patients in this family practice who had received metolazone since its recent introduction, revealed that 19 had been treated for hypertension and 11 for edema.

Most hypertensive patients responded quickly and satisfactorily to the drug, usually, in a dosage of 5 mg once a day. The mean blood pressure reduction was 21/11 mmHg. In 16 patients with diastolic hypertension the mean decrease was 22 mmHg. Many patients who had not responded to other antihypertensive drugs experienced good blood pressure control after receiving metolazone. Control of edema and associated signs and symptoms was also satisfactory. Side effects were typical of those of thiazide diuretics, weakness in seven patients, but in only one case was therapy stopped for this reason.

This was a difficult "test" for a new drug: a widely heterogeneous population, some newly diagnosed, others treated for many years, some receiving a number of other drugs jointly and others none, a wide age range, and most obese. Yet the drug seemed to exert its effects easily across this broad spectrum, despite short treatment periods in many patients. Obviously metolazone will prove very useful in the therapy of these still difficult and often puzzling conditions. ■

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Recent advances have greatly improved the outlook for adults with acute non-lymphocytic leukemia.

New Trends in the Management of Adult Acute Leukemia

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OVER THE PAST decade considerable progress has been made in the management of acute non-lymphocytic leukemia in adults. Prior to 1966 complete remission rates (that is, normalization of blood counts and bone marrow and disappearance of all evidence of organ infiltration) were less than 20 percent.[1-5] The median survival was six months[6] in all patients, 10.5 months in responders to chemotherapy contrasted to 3.5 months in nonresponders. With the introduction of combination chemotherapy, new agents, better supportive measures and a greater understanding of the pathobiology of the disease this dismal prospect is turning to one of optimism. In a recent review of a reported series, Fairley[7] noted that remissions varied from 50 percent to 65 percent. When patients dying the first 4-6 weeks were excluded, 71 percent to 87 percent of patients achieved complete remissions. Except in elderly patients where remissions are less frequent[6, 7] one would expect to obtain a complete remission in about 75 percent of patients.

Chemotherapy

The two drugs most effective as single agents in the treatment of acute leukemia are cytosine arabinoside, an analogue of cytosine, and daunorubicin.[8, 9] Combination of these two agents with other drugs are the most commonly used today for remission induction. In a small series Yates et al[10] reported 87 per cent complete remission rate in patients under 60 years of age.

Support Through Pancytopenic Phase

Complete remissions are obtained at the cost of severe marrow toxicity and patients undergo prolonged periods of aplasia requiring erythrocyte, platelet and in many instances granulocyte transfusions. Although platelets are usually readily available especially in the larger metropolitan areas, granulocytes are much more difficut to supply.

In recent years techniques have been developed to obtain sufficient numbers of granulocytes from single donors to be useful clinically. Two methods have been devised, both designed to remove circulating white cells from the donor and return plasma and red cells. The continuous flow blood cell separator was developed at the National Cancer Institute in the mid 1960's.[11-13] Blood from one arm of the donor is pumped into a centrifuge bowl containing a central core which displaces the blood to the side of the bowl. A flanged lip allows the red cells to sediment toward the periphery and the buffy coat forming at the red cell-plasma interface is continuously removed. The red cells and plasma are recombined and transfused into the other arm of the donor. Methods to increase the yields of granulocytes using hydroxyethyl starch or dextran to obtain a cleaner separation of the buffy layer combined with a pharmacologic agent such as corticosteroids or etiocholanolone, which mobilizes the marginal granulocyte pool, have resulted in sufficiently large yields to be possibly useful in infected, neutropenic patients.[14-16]

A second method of collecting granulocytes in sufficient numbers is by continuous-flow filtration leukapheresis. This procedure involves collecting the blood in heparin, passing it through a nylon filter which traps the granulocytes, and returning the granulocyte-poor blood to the donor. The granulocytes are then eluted from the filter and transfused into the donor.[17, 18]

Using either or both of these techniques several studies have appeared indicating the effectiveness of granulocyte transfusions. Graw et al[19] gave granulocyte transfusions to 39 patients with granulocyte counts of less than 500/mm^3 and documented septicemia. Donors were family members and ABO blood group compatible. They compared the transfused group to a concomitant group of infected neutropenic patients for whom no donor was available. In the control group 29 per cent survived the infection com-

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pared to a 46 per cent survival in the transfused group. All 12 patients receiving four or more transfusions survived which was significantly better than the control group. In a randomized study Higby et al[20] found that significantly more of the transfused group survived 20 days.

Three additional non-randomized studies have been reported which strongly suggest that granulocyte transfusions are of value.[21-23] Despite these favorable reports not all infected neutropenic patients require granulocyte transfusions to survive infectious episodes. Prompt use of appropriate antibiotics is effective in many instances. It would appear that, given the expense involved in obtaining granulocytes, careful study should be given to the selection of the patient most likely to receive benefit from transfusions. A randomized study is underway at Emory University to determine the efficacy of granulocyte transfusions in infected neutropenic patients failing to respond to at least 72 hours of intensive antibiotic therapy. Preliminary results indicate that the recovery from infection and survival are improved by granulocyte transfusions.[24]

Thus the accumulating evidence strongly suggest that granulocyte transfusions are useful in infected neutropenic patients and centers treating acute leukemia should be capable of supplying granulocytes.

Consolidating and Maintaining Remissions

With these supportive measures most patients will live the five to seven weeks necessary to obtain a remission. Once a remission is obtained further chemotherapy is given to "consolidate" the remission. The rationale for this phase of continued intensive chemotherapy is based on the work of Skipper et al[25] and summarized by Skipper and Perry.[26] Kinetic studies have shown that specific drugs kill a constant fraction of proliferating cells and that all leukemic cells must be killed to effect a cure.

The duration of remission depends upon the total fraction of leukemic cells killed and the doubling time of the leukemic population. Thus continuing to treat intensively beyond detectable evidence of leukemia is commonly done. In most instances this consolidation phase is followed by a less intensive treatment, termed maintenance.

Even with all of these chemotherapeutic efforts, relapses occur. More recently evidence has suggested that cellular immunity is somewhat depressed in leukemia[27, 28] and that leukemia associated neo-antigens are usually detectable.[29, 30] Mathé et al reported the successful prolongation of remissions in children with acute lymphoblastic leukemia by immunotherapeutic maneuvers to stimulate the hosts defense against his tumor.[31] They used BCG as a non-specific immunostimulant as well as allogeneic leukemia cells. Subsequently three reports of prolongation of remission in adult non-lymphocytic leukemia were published.[32-34] All employed immunotherapy and chemotherapy in combination. Powles and co-workers[32] reported a median duration of remission of 6 months and a survival of 18 months. Vogler and Chan observed a median remission duration of nine months and survival of 20 months.[35] Gutterman et al[34] found the median duration of remission to be in excess of 18 months.

In conclusion, the success of combination chemotherapy in inducing remissions, the ability to provide sufficient support such as granulocyte and platelet transfusions during remission induction, understanding the necessity to treat intensely after a remission is obtained and the encouraging results of immunotherapy in combination with chemotherapy during the maintenance phase has greatly improved the outlook for adults with acute non-lymphocytic leukemia. Needless to say, this is still an area of intense investigation, but there is room for optimism. ■

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BOARD REVIEWS STATUS OF COMPLAINT INVESTIGATIONS

A major portion of the August 11-12 meeting of the Composite State Board of Medical Examiners was involved with review of complaints—new complaints, status reports on investigations of old complaints and review of completed investigations with determination of action.

Investigators reported that 79 cases had been investigated in the previous 12 months, with 67 completed and returned to the Board. The Assistant Attorney General has 18 cases in his office. Among these, one currently is being heard, two have been completed and are being appealed in court, three are ready for notice of hearing when authorized by the Board, and the remaining cases are in preparation. The Board affirmed or authorized Board hearings on seven cases, received reports on three investigative hearings held since the last meeting and authorized seven new investigations. A total of 46 cases and complaints were reviewed individually by the Board.

Among the routine items handled were the review and approval of requests for replacement licenses, licensing of 15 applicants who passed FLEX but needed their internship completed, 12 institutional licenses and 143 uncomplicated requests for licensure by reciprocity.

Results of the June FLEX examination were reviewed with statistical evidence of some irregularities. The participants involved will be cited for hearing when deemed appropriate by the Board.

Nine applications for reciprocity had some discrepancy from our requirements and will be reviewed by the Board, with one applicant appearing for personal interview.

Five requests were received for extension of time or practice limits by holders of provisional licenses, but only one was approved. One community sent representatives to request certification for eligibility for a provisional license, and this case was reviewed and approved.

Six physician assistants appeared with their sponsoring physicians for interviews. Four required special review of their applications prior to approval.

Common Pitfalls of Perfusion Lung Scan Interpretation

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ACCURATE DIAGNOSIS of acute pulmonary embolism remains an area of clinical medicine that tests the skills of the clinician. Unless meticulous attention is given to the proper assessment of a patient's presenting clinical information and to the subsequent interpretation of laboratory data, pitfalls await the unsuspecting physician.

The introduction and clinical application of radioisotope perfusion lung scanning has greatly enhanced the clinician's ability to make an accurate assessment when pulmonary thromboembolic disease is suspected. Yet, without attention to coexistent pulmonary and other chest abnormalities, misinterpretation of the perfusion lung scan may lead to an unwarranted diagnosis of pulmonary embolism.

Three clinical situations are described in which caution must be exercised in the interpretation of abnormal perfusion lung scans.

Case Reports

Pitfall 1: The Wheezing, Asthmatic Patient (C. W. 0-184528)

A 54-year-old male with a history of bronchial asthma was hospitalized because of the sudden onset of pleuritic chest pain and wheezing. Pertinent physical findings included tachycardia, tachypnea, and expiratory wheezes. There was no evidence of thrombophlebitis. The chest x-ray is shown in Figure 1-A. Arterial blood gas determinations were pH 7.31, pO_2 80 mm Hg, and pCO_2 47 mm Hg. The perfusion lung scan was considered positive for pulmonary embolism (Figure 1-B). Because of persistent wheezing at the time of lung scanning, the test was repeated after 24 hours of bronchodilator therapy; the repeat lung scan was entirely normal (Figure 1-C).

Comment: This case demonstrates the problem of interpretation of a "positive" lung scan in a patient with bronchial asthma who is wheezing; this is known to produce perfusion abnormalities indistinguishable from those of pulmonary embolism.[1] Bronchodilator therapy completely corrects the abnormal perfusion and abnormal lung scan. Ventilation lung scan studies, using radioxenon, would be of great assistance in this situation, since the impared ventilation in the asthmatic patient can ana-

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FIGURE 1-A

PA chest x-ray with slight over-inflation of both lung fields. There is no other abnormality.



FIGURE 1-B

March 25, 1971. Perfusion lung scan. Anterior standard rectilinear projection revealing a perfusion defect in the superior portion of the right lung.



FIGURE 1-C

March 26, 1971 (after 24 hours of bronchodilator therapy). On an identical projection as in Figure 1-B, no evidence of a perfusion defect is present on the lung scan.



FIGURE 2-A

Chest x-ray—lateral projection illustrates the presence of a severe pectus excavatum deformity.



FIGURE 2-B

Anterior (L) and posterior rectilinear perfusion lung scans show diminished perfusion of the left lung in an anterior distribution. The left lung is displaced posteriorly and laterally by the mediastinal contents which, in turn, are displaced by the pectus deformity.

tomically define and clarify the defect on the perfusion lung scan.

Pitfall 2: The Patient with Chest Wall Deformity (M. S. 0-468203)

A 47-year-old female was hospitalized because of the sudden onset of cough, hemoptysis, and left pleuritic chest pain. Chest x-ray was normal except for an obvious pectus excavatum. Arterial blood gas determinations were pH 7.42, pO_2 66 mm Hg, pCO_2 39 mm Hg. The perfusion lung scan is shown in Figure 2-A and the pulmonary angiogram in Figure 2-B. Anticoagulant therapy was not considered indicated and the patient was treated with broad spectrum antibiotics for presumed acute bronchitis. All symptoms subsided.

Comment: Despite the symptoms and the abnormal lung scan which suggested acute pulmonary embolism, a pulmonary angiogram did not document the presence of a pulmonary embolus. The angiogram was obtained to clarify the role of the severe chest wall deformity in the production of the abnormal lung scan. The difference in apparent lung perfusion was caused by a difference in rectilinear scanner positioning in relation to lung tissue.

Undoubtedly, more subtle chest wall abnormalities may also confuse the clinician. In such cases, a lung scan obtained with a gamma camera, aligned in normal incidence to the largest lung volume, will "see" the normally perfused lung. Thus, one can avoid the diagnostic pitfall encountered in standard use of rectilinear scanner positioning and collimator characteristics.

Pitfall 3: The Patient with a Pneumothorax (S. F. M. 0-276608)

A 65-year-old male was hospitalized with congestive heart failure and anasarca of unknown etiology. Admission chest x-ray revealed cardiomegaly

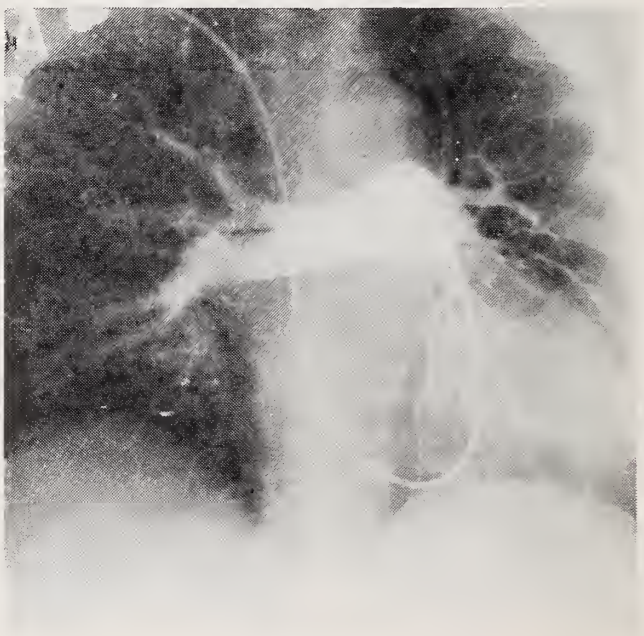


FIGURE 2-C

The pulmonary angiogram shows no evidence of pulmonary embolism. There is minimal vascular displacement. There are no arterial cutoffs or intravascular clots.

and a large right pleural effusion. Thoracentesis was performed, with symptomatic relief. Several hours later, the patient suddenly developed right pleuritic chest pain and increasing dypsnea. A previously scheduled lung scan revealed a marked diminution in perfusion of the right lung. The chest x-ray was immediately repeated and revealed a 50 percent right pneumothorax. Following insertion of a chest tube and re-expansion of the right lung, a second lung scan was entirely normal (Figure 3-A, B).

Comment: This case illustrates the need for correlation of all data available to the clinician. In the setting of severe congestive heart failure, there is increased suspicion of a pulmonary embolus when sudden clinical deterioration occurs. But the clinician must consider all diagnostic and therapeutic interventions which have been performed. In this case,

the occurrence of a pneumothorax had many presenting characteristics similar to those of acute pulmonary embolus. The perfusion lung scan was considered compatible with acute pulmonary embolus, but a concurrent chest roentgenogram clarified the problem.

Discussion

The accurate diagnosis of pulmonary embolus remains difficult. The classic triad of thrombophlebitis, pleuritic pain, and hemoptysis is present in only a small portion of patients with documented pulmonary embolism. In one series, the analysis of these three clinical manifestations, either singly or in combination, permitted the correct diagnosis of pulmonary embolism with a certainty no greater than one in three.[2] Obviously laboratory and other special studies are needed for proper assessment.

Prior reports indicated that arterial hypoxemia with a pO_2 of less than 80 mm Hg was highly suggestive of acute pulmonary embolism.[3] In the Urokinase Pulmonary Embolism Trial, using pulmonary angiography as the definitive confirmatory test for embolism, 12 percent of patients documented to have pulmonary embolism, had a pO_2 greater than 80 mm Hg, but usually below 90 mm Hg.

The introduction of perfusion lung scanning has enhanced the clinician's ability to make a correct diagnosis. Perfusion scans are sensitive in detecting massive, segmental, or multifocal perfusion defects. A pulmonary angiogram compatible with pulmonary embolism is characteristically associated with an abnormal perfusion lung scan.

The specificity of the perfusion lung scanning, however, is modest when compared with its sensitivity. Many pulmonary diseases are characterized by decreased pulmonary arterial blood flow. Therefore, specific etiologic interpretation of a lung scan perfusion defect requires careful correlation with the entire clinical picture and other laboratory data or special studies. The three cases serve to illustrate this point. Perfunctory acceptance of pulmonary embolism as an etiologic explanation for a perfusion defect on lung scan, even though suspicion of pulmonary embolus is high, is fraught with hazard. Even after the elimination of diagnostic pitfalls, the accuracy of the perfusion lung scan is only 65 percent to 75 percent, compared with angiographic confirmation of pulmonary embolism. Concurrent, non-embolic pulmonary disorders account for most of the false positives.[4–6]

Enhancement of radioisotopic perfusion lung scan specificity is currently the objective of considerable research. An important advance was the introduction of ventilation-perfusion scans, using radioactive gas. When simultaneous ventilation-perfusion lung scans are performed in patients with pulmonary parenchymal abnormalities, ventilation and perfusion defects correspond. In defects due solely to pulmonary embolism, only perfusion abnormalities are detected and the ventilation scan is entirely normal. Ventilation-perfusion scans using radioactive gases, such as xenon-133, will define segmental and generalized obstructive pulmonary disorders both anatomically and functionally. This technique offers considerable advantage in diagnosis since it further discriminates in the selection of patients for more invasive procedures.

Pulmonary angiography remains the most specific diagnostic procedure for pulmonary embolism. In the hands of an experienced angiography team, the



FIGURE 3-A

PA projection of the chest x-ray reveals a partially reduced right pneumothorax. Thoracotomy tube has been inserted. There is residual pleural fluid near the base of the right hemithorax.

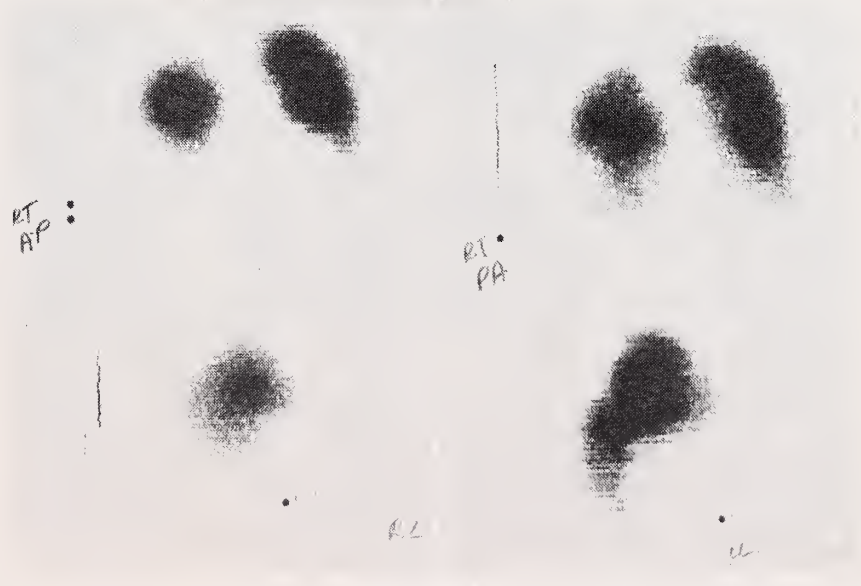


FIGURE 3-B

Four standard rectilinear views of the lung scan show a non-segmental, inferolateral perfusion defect in the right lung. This area corresponds to accumulated air from the pneumothorax (see chest x-ray—Figure 3-A).

risk is minimal even for critically-ill patients. This procedure should be reserved for cases in which the probability of pulmonary embolus is high and prior non-invasive studies are either inconclusive or non-discriminating, and is mainly indicated only when surgical procedures (vena caval interruption, pulmonary embolectomy) are contemplated.

Approach to Diagnostic Accuracy

The primary requisite for the diagnosis of pulmonary embolus is a high index of suspicion based upon clinical signs and symptoms in a patient predisposed to pulmonary embolism e.g., patients with recent surgery or immobilization, with congestive heart failure, phlebitis, etc. Unexplained dyspnea, tachycardia, chest pain, fever, heart failure, hypoxemia, and a sudden deterioration of a previously stable patient are among the leading signs and symptoms suggesting this diagnosis. Thus, a careful history and physical examination are of great importance. Particular attention should be directed to body habitus, chest wall abnormalities and to complications of recent therapeutic or diagnostic procedures. Next, the chest x-ray (PA and lateral views) and a perfusion lung scan should be reviewed for comparison. Correlation of x-ray and perfusion scan studies yield four general categories of interpretation.

1. Normal Chest X-Ray, Normal Perfusion Scan

The probability of pulmonary embolus is unlikely. Other diagnosis should be considered.

2A. Normal Chest X-ray, Abnormal Perfusion Scan (focal) segmental perfusion defect

In the setting of signs and symptoms suggesting pulmonary embolus, this combination of laboratory data increases the likelihood of pulmonary embolus. Angiography may be necessary for definitive diagnosis, only if a local structural or anatomical abnormality is present.

B. Normal Chest X-ray, Abnormal Perfusion Scan (multifocal) segmental perfusion defect

This combination virtually is diagnostic of pulmonary embolus. Pulmonary angiography is recommended only if there are local anatomic abnormalities, as in 2A, above.

3. Abnormal Chest X-ray, Normal Perfusion Scan

This combination may be explained by compensated perfusion on the lung scan, or by a pulmonary abnormality without significant impairment of blood flow, as occurs with many miliary lung lesions. Small lesions; "coin lesions"; bony, mediastinal, and chest wall abnormalities evident on the chest x-ray often do not impair ventilation or perfusion mechanisms.

4A. Abnormal Chest X-ray (focal), Abnormal Perfusion Scan (focal)

If focal abnormalities are present in the same bronchopulmonary segment, the scan does not add further specificity to the diagnosis. Pulmonary angiography may be required to clarify the problem.

B. Abnormal Chest X-ray (focal) Abnormal Perfusion Scan (multifocal)

This combination is highly suggestive of multiple pulmonary emboli if the scan defects have a segmental distribution. Pulmonary angiography usually is not indicated. If the scan defects are nonsegmental in distribution, angiography should be considered, as in 4A, above.

C. Abnormal Chest X-ray (multifocal), Abnormal Perfusion Scan (multifocal)

The specificity of this combination of abnormalities is low. Pulmonary angiography is indicated to diagnose pulmonary embolism. ■

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The wide variations of the normal and abnormal S-T segment are discussed.

The S-T Segment—Help or Hindrance?

GERALD F. FLETCHER, M.D., *Atlanta**

THE S-T SEGMENT of the scalar electrocardiogram (or the RS-T junction) was defined specifically in standard nomenclature in the *American Heart Journal* in 1943.[1] At this time, Doctors Barnes, Katz, Levine, Pardee, White, and Wilson described this event in the cardiac cycle as follows: (quoted in part)

> "The term RS-T junction should be used to indicate the point or shoulder which marks the end of the QRS complex, i.e., the point where the steep slopes of the QRS deflections are more or less abruptly replaced by the more gradual slopes which precede or comprise the first limb of the T wave. In many electrocardiograms the RS-T junction is followed by a nearly horizontal or gently sloping segment which lies on, above, or below the reference level, and ends with the onset of a much steeper slope that rises or falls to the apex of T. It is agreed that the term RS-T segment is a useful name for this part of the ventricular complex when it exists, even though it is proper to regard it as the earliest part of the T deflection. When there is no point between the RS-T junction and the apex of T at which a sharp change in the slope of the trace occurs, this part of the ventricular complex should be called the first limb of the T wave."

As related in this description there is often no clearly defined point of beginning or ending of the S-T segment in many electrocardiograms. However, the use of this segment has been very instrumental in patient evaluation in disorders of the cardiovascular system and is often quite influential in a patient's future depending on clinician interpretation. With our current pandemic of coronary atherosclerotic disease, S-T changes—both at rest and with exercise—have been utilized in management as well as in the detection of early signs of this disease, both in subjects with and without symptoms.

There are many normal S-T segment alterations. These occur with tachycardia, position changes,[2] hyperventilation, temperature (specifically cold[3]) and various states of autonomic nervous system imbalance. Serum electrolyte alterations cause depression of the S-T segment with states of low potassium,[4] prolongation of the S-T segment with low calcium, shortening of the S-T segment with high calcium and variable S-T changes with acid base imbalance.[5] In addition, there are specific heart tissue S-T changes which are very helpful in patient evaluation—namely epicardial injury which elevates S-T segments, subendocardial injury which causes S-T depression and pericarditis which elevates selectively and somewhat differently various S-T segments in various leads of the scaler electrocardiogram.[6] Positive S-T changes for ischemic heart disease usually manifest as S-T depression, however, S-T elevation, depression of the upslope of the S-T segment and, at times, normalization of the S-T segment, have been observed in our laboratories as well as others.[7]

All of the aforementioned changes must be considered in lieu of effects of other events in the cardiac cycle on the S-T segment. Repolarization of the atrium (or the Ta wave) is a specific event which often is overlooked.[8] Ta wave influence is more pronounced with right atrial enlargement and more significant with tachycardia. In such states the cardiac cycle is shortened and the Ta wave may superimpose its effect on the QRS and the following J junction and S-T segment. In addition, the U wave (such as in cases of hypokalemia) and associated changes in the T wave may influence the terminal portion of the S-T segment.

With regard to the exercise electrocardiogram, we have had considerable experience in our institution with false positive changes. These usually occur in subjects on drugs, with certain states of cardiac enlargement, electrolyte abnormality and other physiologic states. A number of these are noted in Table 1.

We feel the judicious use of the S-T segment, both at rest and with exercise, is most valuable in patient care and management, however, it may be a hindrance as well as help in the patient's outcome if the aforementioned factors are not carefully considered. Misinterpretation of the S-T segment and "labeling"

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the normal patient with possible cardiovascular disease may provoke cardiac neurosis and impair functional capacity. On the other extreme, overlooking abnormal S-T segments that support disease in a given patient is regretable in that remedial or preventive measures may not be employed. ■

TABLE 1

CAUSES OF FALSE POSITIVE

Digitalis	**Catecholamines**
Beta blocking agents	**Glucose meal**
Quinidine	**Electrolyte changes**
Diuretics	**Hypertension**
Phenothiazines	**Bundle Branch Block**
Rauwolfia	**Ventricular hypertrophy**
Nicotine	**Hyperventilation**

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ASK MEDICARE . . .

Q: Does completion of Part II of the Request for Medicare Payment imply that we are accepting assignment?

A: No, the doctor indicates his choice of payment by checking the appropriate block in section 12. Putting itemization on the claim form ensures that it will be processed faster because the required information has been given; also Part II can be used in place of a receipted bill.

Q: We haven't heard when Medicare B Workshops will be held—usually they are scheduled in October and November, and we find them very helpful. Can you tell us the dates for this year?

A: Prudential will conduct workshops for medical assistants in early Spring 1977. Details along with registration forms, will be issued some time in January.

Q: I am newly licensed and about to begin my practice. Do I need any special approval to qualify for Medicare reimbursement?

A: No special approval is required. However, any physician intending to submit Medicare claims should contact the Medicare office (404-325-5666, ext. 114), so we may obtain the information necessary for adding a new physician to our roster. This must be done prior to submitting claims. Failure to do so will preclude their being processed.

Q: Why haven't I heard about my Medicare claim that was submitted several weeks ago?

A: Maybe it was not completely itemized—that would cause a delay. In addition, if the "I accept assignment" box is not checked, payment would go to your patient and you would not be informed that the claim was processed. When Medicare-B claims are properly made out, the average processing time is about 10 days, according to the Georgia Part B carrier, Prudential Insurance Company. In fact, 55 percent of the claims are processed in five days or less. We suggest that you write to the Medicare office about any claims that are outstanding for more than 60 days.

Q: What is involved in acceptance of assignment on a Medicare claim?

A: An assignment is an agreement between a physician (or other supplier of services) and a beneficiary. Under the terms of the assignment the patient transfers to the physician his rights to benefits based on covered services specified on the claim. Medicare's payment goes directly to the physician who agrees in return to consider as his full fee the reasonable charge determined by the carrier. He is precluded from collecting (or attempting to collect) from the patient or anyone else, any amount which when added to Medicare's payment is in excess of the allowable amount.

Q: How are non-assignment claims submitted?

A: Non-assignment payment for Part B services is made to the Medicare beneficiary on the basis of an itemized bill, accompanied by a *signed* Request for Payment form. Although there is no obligation to do so, physicians' offices are encouraged to complete the 1490 as a courtesy to their elderly patients. Such claims are less likely to require subsequent development and/or contact with the physicians' offices than those completed by the beneficiary.

Q: Regarding the Medicare deductible, how exactly does it work?

A: The carrier applies covered expenses toward the deductible in the same order that the bills are received. If the deductible is not satisfied during any given year, expenses incurred during the last three months of that year may be carried over, and count toward the deductible for the next year.

Q: Is there a time limitation for submitting Medicare claims?

A: Yes, claims involving services performed between October 1, 1974 and September 30, 1975 must be filled by December 31, 1976. You may wish to review your accounts for claims, submitted during this period for which you have not received payment. There still is time to send an inquiry to the Medicare office and resolve the delaying problem before the deadline.

Scientific Assembly Reflects Educational Commitment

NEXT MONTH, on November 19 and 20, the Omni International Hotel in downtown Atlanta will host the Annual Scientific Assembly of the MAG.

In the past few years, much has been written and said in both the medical and lay press about the quality of medical care. We are constantly being challenged to maintain the high level of care the public, and indeed our colleagues, expect. To accomplish this, the major thrust has logically been an increased intensity in the area of professional education. Fortunately, Georgia has an established mechanism and a good track record in this area. Our two fine medical schools, as well as local medical societies and specialty groups, have recognized their responsibility in this field for years by providing avenues for postgraduate education. In keeping with this responsibility, the MAG has planned the Annual Scientific Assembly. 1975 witnessed a new format for our annual meeting. It was separated both geographically and temporally from the MAG business meeting in order to emphasize the educational commitment of our Association. The format is that of a forum for our many state specialty societies to present their own programs. Several will hold joint meetings, such as the Georgia Radiological Society and Georgia Gastroenterologic Society with a program on the biliary tree. A total of some 13 specialty societies will present programs this year.

Last year we all enjoyed Dr. Anne Somers' presentation of the Abner Calhoun Lecture on the subject of consumer health education. This year we are delighted to have Dr. Jack Myers, currently President of the American College of Physicians and Professor of Internal Medicine at the University of Pittsburgh, present the Calhoun Lecture. Many of you know Dr. Myers from his days on the faculty of Emory University Medical School. The lecture will be given at a MAG-hosted luncheon on November 19 for all attending the Assembly.

Elsewhere in this issue is a detailed description of the program. Emory University, Medical College of Georgia, and Tulane University medical alumni groups will host receptions. Application for AMA Category 1 credit towards the Physician's Recognition Award and AAFP credit has been made. An excellent educational program for the wives will be different from the usual wives' programs seen at medical meetings. In addition, the new Omni International will offer an excellent diversion for spouses, with entertainment as well as the opportunity to get a jump on Christmas shopping.

We feel this year's program will be both fun and beneficial and look forward to seeing you in November.

James K. Van Buren, M.D.
Chairman, Planning Committee
1976 MAG Scientific Assembly
490 Peachtree Street, N.E.
Atlanta, Georgia 30308

president's letter

Supporting the 1976 Scientific Assembly



WHY SHOULD I GO to the Annual Scientific Assembly? I don't think one should if he doesn't plan to make it worth his time, money and effort.

With the advent of a separate scientific session last year, MAG stood on two separate legs—a scientific session and its business session. Will it walk or fall flat on its face?

The education limb of MAG has struggled and made a gratifying impact through its continuing medical education format.

Elsewhere one will find more detailed information on the November Scientific Assembly at the Omni.

On the positive side, the specialty societies have developed a worthy program. It provides a vehicle to discuss current medical issues with your statewide peers. Alumni get-togethers renew some current events at a halfway point in the year.

Another meeting in Atlanta scheduled November 1-3 is the American Association for Automotive Medicine. Some of you interested in medical aspects of driving handicaps might find it a worthwhile meeting. Reporting of medical disabilities will be one of the issues.

A one day session on Decision Making in Medical Practice co-sponsored with Emory University may have occurred before the October MAG *Journal* has reached you.

So with the coming of the fall season MAG makes its effort to provide a wider scope of services to its membership.

Congratulations to Wilbur Baugh and Ray Rowland for their election victories to the General Assembly. See you at the voting machine November 2.

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Can Deaths From Cancer of the Cervix Be Reduced in Georgia?

CAROL STEINER, R.N., M.N., *Atlanta**

SOME 174 WOMEN died from cancer of the cervix in Georgia during 1974.[1] The average number of deaths during the five year period, 1970-74, was 180 deaths per year or 7.3 deaths per 100,000 females. One in every 63 females born will probably develop invasive cancer of the cervix uteri.[2] Is there an effective way to reduce these deaths? The Georgia Department of Human Resources (DHR) is trying to answer this question.

The National Cancer Institute (NCI) has awarded a contract to expand the Department of Human Resources cervical cancer screening program to reach more of the high risk women. Since 1967, Georgia public health agencies have been providing pap smear screening to the medically indigent population primarily through family planning and prenatal clinics. This new program is designed to expand these services to reach medically indigent women over the child bearing age, who *have not* been receiving cervical cancer screening on a yearly basis.

The primary target groups for this program are populations in which a majority of the women:

1. Are above child bearing age,
2. Are in the low socio-economic group,
3. Do not generally respond to screening programs, and
4. Have a high mortality rate from cancer of the cervix.

The objectives of this program are:

1. To screen 9,000 women who have not had pap smears within the last two years, and
2. To evaluate recruitment techniques to determine which are most effective in reaching this target population.

The Adult Health Section of DHR is funding health districts and nonprofit health care agencies to implement this program. The provider of the services agrees to recruit, screen, and follow the study population for three years. At the present time, the following agencies are participating in the project: 17 of the 19 DHR Health Units, Grady Memorial Hospital, Southside Comprehensive Health Center, and Emory Community Nursing Service.

Population Groups at High Risk

In reviewing the literature, several occurrences have been associated with increased incidence of cancer of the cervix; the most frequently identified are coitus at an early age and multiple sexual partners. It is hypothesized that these events are linked with carcinogenesis of the cervix because biological activity in the cervical cellular matrix is at a maximal level during early adolescence. This accelerated biological activity increases the probability that division of susceptible cells can

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take place following the initiating stimulus of a carcinogenic influence. Probability of this occurring decreases as fewer divisional events take place.[3]

Demographic characteristics which have been associated with the *highest* incidence of cervical carcinoma are: low socio-economic status, the black race, and early marriages.[3, 4] These characteristics have been directly or indirectly associated with coitus at an early age. Demographic characteristics, associated with the lowest incidence of cervical carcinoma, are celibates such as nuns.[5]

Highest Risk Groups in Georgia

An examination of the cervical cancer death rate in Georgia by age, race, and residence, provides the following picture. The death rate increases with age, from 1.58 per 100,000 females in the 25-29 year age group to 35.97 per 100,000 in the 85 year and over age group. (Figure 1) The death rate for blacks is 2.5 times the rate for whites; 13.4 and 5.16 respectively. The counties with the highest death rates are scattered throughout the state, but tend to cluster predominantly in the middle and southern portions of the state. (Figure 2)

Patterns of early diagnosis tend to mirror the death rate data. The percentage of women diagnosed in the "in situ" stage decreases as age increases with a significant drop off over age 40. The percentage of women diagnosed in the later stages of the disease increases with age. (Figure 3)

In Georgia, the populations at the highest risk are the older age groups and the blacks. No data for Georgia are available regarding socio-economic group or marital patterns.

Groups Without Pap Smear Screening

In an analysis of data from the National Health Interview Survey,[7] the following pattern emerges:

1. The percentage of women who have never had a pap smear, increases as income decreases. (Table 1)

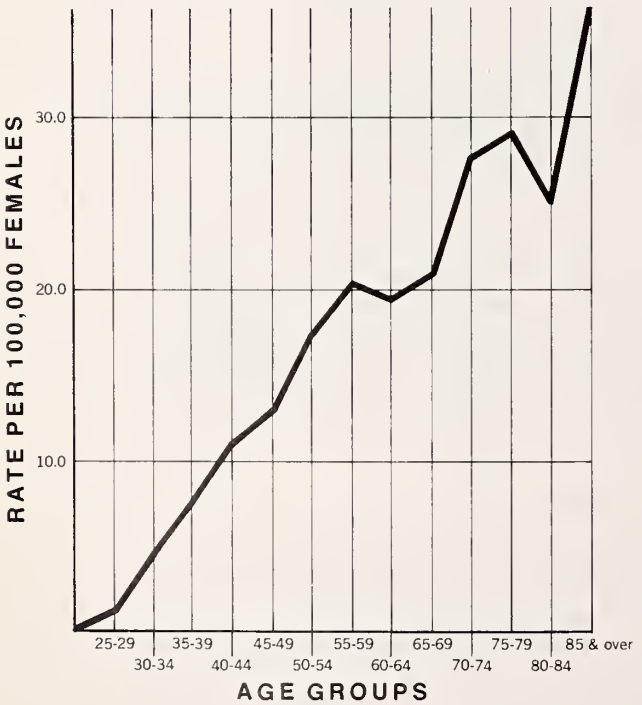


FIGURE 1

Cervical cancer death rate per 100,000 females by age group, 1970-74, Georgia.

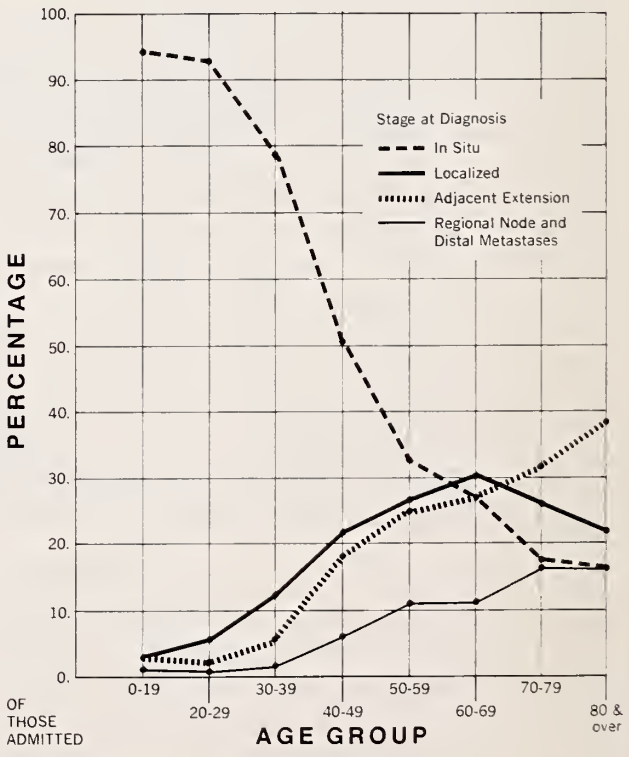
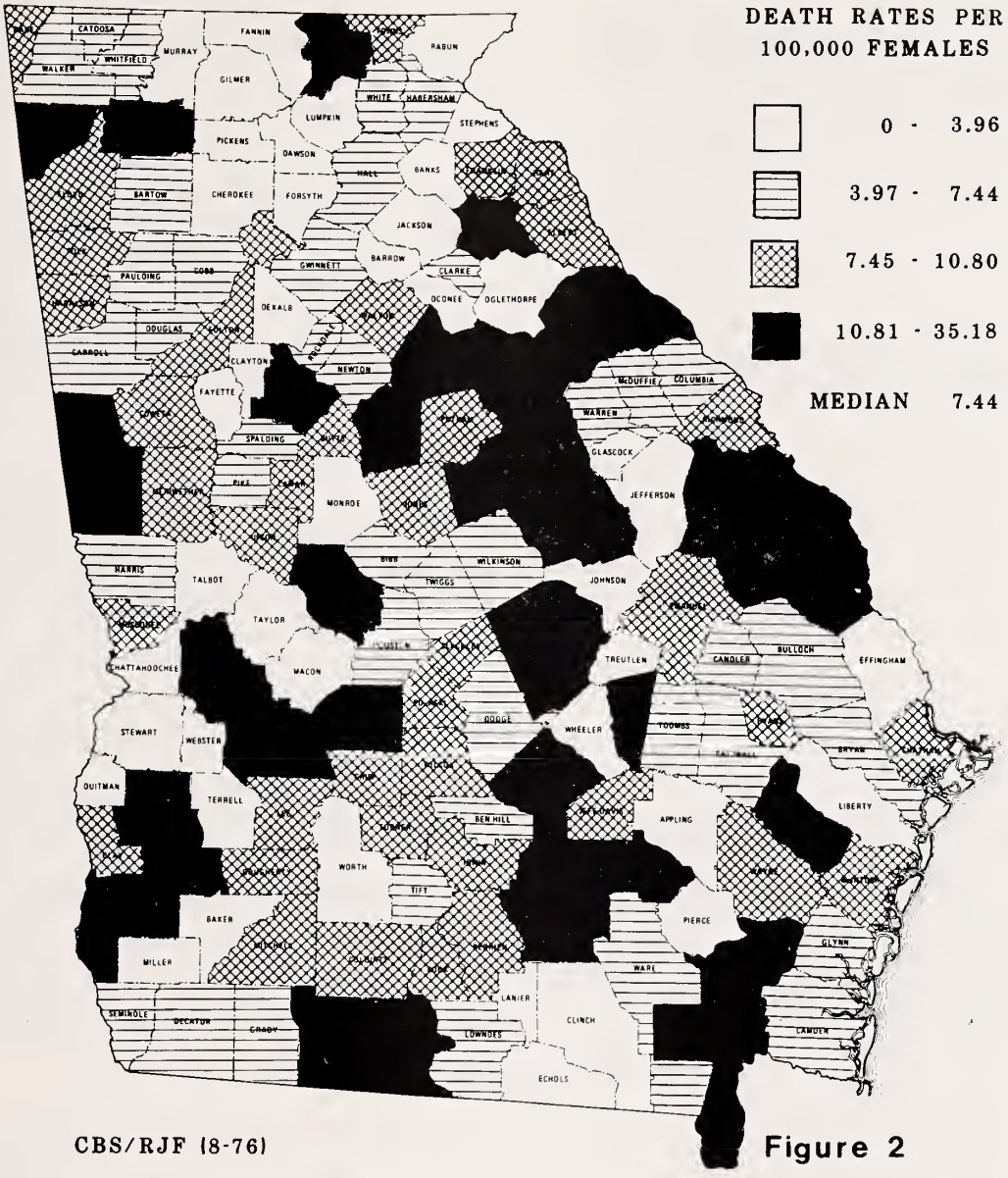


FIGURE 3

Percentage of females entered on the Georgia tumor registry by age and clinical staging at initial diagnosis, Georgia, 1970-74.[6]

CERVICAL CANCER DEATHS
GEORGIA 1970 - 1974



CBS/RJF (8-76)

Figure 2

2. The percentage of women who have never had a pap smear is significantly higher in the younger (17-24) and the older (65 and older) age groups. (Table 2)

3. The percentage of blacks and whites who have never had a pap smear is similar; 24.8 and 20.5 respectively.

The lower income, older female is not only at higher risk of cervical cancer, but also fails to seek early detection and diagnosis.

This analysis of pap smear screening participation, stage at time of initial diag-

TABLE 1

PERCENT OF FEMALES 17 YEARS AND OVER NEVER HAVING A PAP SMEAR, ACCORDING TO FAMILY INCOME, U.S., 1973[7]

Family Income	Percent
All Family Incomes	21.0
$10,000 or more	15.2
$5,000-$9,999	19.4
Less than $5,000	33.8

TABLE 2

PERCENT OF FEMALES 17 YEARS AND OVER NEVER HAVING A PAP SMEAR, ACCORDING TO AGE GROUP, U.S. 1973[7]

Age Group	Percent
All Females, 17 years and over	21.0
17-24 years	34.7
25-44 years	7.5
45-64 years	17.1
65 years and over	40.5

nosis, and mortality rates, has assisted in defining the scope of this study. The target population has been defined as lower income, older females who have not had a pap smear within the last two years. In Georgia, there are approximately 45,000 women in this category. The project goal is to screen one fifth or 9,000 of these women during 1976.

The major problem encountered thus far is that the target population is not easily recruited. There seem to be various reasons for this. These women often do not perceive themselves as being susceptible to cancer of the cervix because they are beyond the child bearing years. These women are often afraid to have a pap smear because they are unfamilar with the procedure. Many of these women seek episodic or crisis medical care; but not preventive services. In the past the health departments have not provided these services for the older adult, and consequently they may not realize that screening is available.

With the assistance and support of the medical community, the American Cancer Society, Georgia Division, and other human service organizations, the goal of this program, to screen the hard-to-reach, high-risk women, can be achieved. Georgia has the opportunity to decrease the death rate from cervical cancer. This national study should help us learn the most effective way to accomplish this.

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PRESIDENT OF AMERICAN COLLEGE OF PHYSICIANS TO ADDRESS SCIENTIFIC ASSEMBLY

The principal speaker at MAG's Scientific Assembly will be Jack D. Myers, M.D., President of the American College of Physicians. Dr. Myers will deliver the Abner W. Calhoun Lecture at the general luncheon on Friday, November 19, addressing the topic "The Distribution of Training Opportunities in Graduate Medicine."

A native of Pennsylvania, Dr. Myers received his medical training at Stanford University and began his teaching career at Emory University in 1946. He has been Professor of Medicine at Duke University and The University of Pittsburgh and a visiting professor at 16 universities, as well as the author of a number of articles appearing in scientific journals.

Chairman of the National Board of Medical Examiners in 1971-75, Dr. Myers has taken a keen interest in the relation of medical education to the quality of medical practice. He has served recently as Chairman of the Liaison Committee on Graduate Medical Education (LCGME) and its umbrella organization, the Coordinating Council on Medical Education (CCME).

Chest Pain—The Diagnostic Dilemma

ARTHUR J. MERRILL, JR., M.D., *Atlanta**

A PATIENT WITH CHEST PAIN can be one of the most difficult diagnostic/therapeutic dilemmas in medicine. The individual who presents with severe, prolonged chest pain and enzyme and ECG evidence of myocardial infarction obviously has coronary atherosclerotic heart disease. The same is true of those with typical substernal pressure occuring during exercise and subsiding in one to five minutes with rest or Nitroglycerin. Patients with other types of pain may or may not have coronary disease. Those patients with ST or T wave changes on electrocardiogram and less specific chest pain may be labeled as having coronary atherosclerosis with resulting limitations in lifestyle and psychic trauma—over half of these patients will have normal coronary arteriograms and an extremely good prognosis.[1]

At the other extreme, a patient may present in an Emergency Room with epigastric pain, be treated with Maalox and sent home only to die suddenly at home. Indeed, sudden death is the first manifestation of ischemic heart disease in 15 percent of patients. About 25 percent of these patients will see a physician in the two to four weeks prior to death.

Careful History Essential

What clinical clues can a physician use to unravel the often complex picture with which many patients present? First, a very careful history is essential. The duration of *pain* is important. Pain that lasts only seconds is rarely due to coronary disease, even if it recurs over a period of five to ten minutes. Pain that lasts longer than 15 minutes to 20 minutes is either very severe myocardial ischemia or due to some other cause. If discomfort persists for days, look for a reason other than coronary atherosclerosis.

Precipitating Factors: Exertional and anxiety related chest discomfort or tightness is classical for angina. If pain is related mainly to anxiety, other symptoms of hyperventilation should be searched for: circumoral paresthesias, paresthesias of fingers *and* toes; shortness of breath and lightheadedness. Chest pain due to hyperventilation may sound exactly like angina but may be preceded by shortness of breath; only if congestive failure occurs does dyspnea precede true angina. More often, dyspnea may occur after the onset of angina due to transient heart failure.

Many patients with non-coronary pain will complain of exertional discomfort, but with close questioning, they admit that their pain really does not start until after exercise ceases rather than during physical activity. A good question is "Have you ever had occasion to walk up a hill in cold weather after eating a big meal?

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Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

If so, has this bothered your chest?" If this causes discomfort that ceases within five minutes, the patient probably has angina. Substernal burning during exertion undertaken after meals most often is angina, but burning that occurs only when lying down after a meal may be due to a hiatal hernia. One must remember, however, that hiatal hernia pain or other gastrointestinal problems occur with equal frequency in patients with ischemic heart disease as in the general population.[2] Some authors also feel that hiatal hernia pain may also precipitate classical angina by a reflex mechanism.[3]

Nitroglycerin Trial

A trial of Nitroglycerin is also worthwhile—pain relieved in one to five minutes may well be angina. 95 percent of patients with chest pain responding within five minutes to Nitroglycerine have abnormal coronary arteriograms.[4] If a person's pain response to Nitroglycerin is equivocal or relief takes longer than five minutes, the likelihood of the patient having coronary atherosclerosis as the cause of the pain is much less.

Physical Exam: The physical exam is often normal in patients except during angina. Auscultation during spontaneous chest pain can be very helpful—many patients will develop a presystolic atrial gallop, an apical systolic murmur, or more rarely, a ventricular gallop or paradoxical splitting of the second heart sound. If these findings are present only during pain, they are virtually pathognomonic of angina. These physical findings are not specific if they are also present when the patient is pain free.

Electrocardiogram: The electrocardiogram is normal at rest in up to 50 percent of patients with angina—often even in those with all three coronaries severely narrowed. Flat ST segment depression of 0.5 mm appearing during spontaneous pain is a good indication of coronary atherosclerosis. Unfortunately, this change occurs in only the minority of patients. Other changes such as T wave inversion after prolonged pain are not nearly so specific and may occur in many conditions such as hyperventilation, hyperadrenergic states such as anxiety, and electrolyte problems as well as in subendocardial ischemia. Even Q waves suggesting old myocardial scars can be seen in conditions other than coronary atherosclerotic heart disease, such as: left ventricular hypertrophy, hypertrophic subaortic stenosis, asymmetric septal hypertrophy and other myocardial disease.

Exercise Testing: Exercise testing by the bicycle ergometer or treadmill can be helpful in the diagnosis of difficult cases but generally should not be done in patients with crescendo pattern of pain or recent episodes of prolonged chest pain (within eight to 12 weeks). If the patient with a normal resting electrocardiogram develops classical angina and 1 mm ST segmental depression during exercise, this is almost certainly due to coronary atherosclerotic heart disease. In the absence of chest pain or with less specific chest pain, a positive electrocardiogram (1 mm ST depression) is not diagnostic since there is an incidence of 15 percent false positives. Up to 40 percent of patients with left ventricular hypertrophy or non-specific abnormalities on the resting ECG may have false positive exercise ECGs. More important, up to 50 percent of patients with single vessel disease and one-third with two vessel disease may have a negative maximum exercise test. Non-diagnostic tests (junctional depression or less than 1 mm of flat SD depression) are of no help in ruling out coronary atherosclerotic heart disease.

Arrhythmias or hypotension during exercise may indicate ischemic heart disease but also may occur in any kind of myocardial disease. Auscultation immediately after exercise may show an S_4 or mitral regurgitant murmur or rarely an S_3. These are additional evidence of myocardial dysfunction if the patient develops typical angina, but are not diagnostic of ischemic heart disease in the absence of typical

pain and ST depression. Palpation of the costochondral junctions and chest wall immediately following maximum exercise will cause discomfort in most patients. If it reproduces a patient's pain exactly and is unaccompanied by ECG changes, one can be reasonably certain that the pain reproduced is not angina. One must always remember that 50 percent of patients with angina have musculoskeletal chest pain also.[5]

When chest pain occurs during exercise, observation of the time course of the pain, and associated symptoms such as paresthesias of hyperventilation or the respiratory variation of non-coronary chest pain will be of help. Typically anginal pain will subside within five minutes of ceasing exercise as mentioned previously.

Thus there are many diagnostic clues from history, physical and electrocardiogram and observation during exercise testing that can help separate the patient with coronary atherosclerotic heart disease from patients with other types of chest pain. Only the typical history of exertional chest discomfort relieved by rest or Nitroglycerin in one to five minutes is diagnostic—95 percent of patients with this history will have coronary atherosclerosis in the absence of valvular disease or left ventricular hypertrophy. Any variation from this history increases the liklihood of non-coronary chest pain. The physical findings of an S_4, systolic murmur or S_3 gallop occuring during pain and absent at rest are confirmatory evidence that the chest pain is angina. An ischemic ST response to exercise is additional confirmation but may be absent in as many as one-third of the patients with angina and false positives are not uncommon. T wave changes are completely nonspecific.

Suggest Coronary Arteriograms

If the etiology of a patient's chest pain is still unclear after a history, physical exam and exercise test, I feel that one should refer the patient for coronary arteriograms to resolve the issue. The psychological and economic consequences of incorrectly labeling a patient as having coronary atherosclerotic heart disease include uninsurability, often disability retirement, and the fear of patient and family of sudden death or infarction. A patient with chest pain but normal coronary arteriograms can be reassured that his chances of heart attack are less than 0.4 percent per year and death from heart disease less than 0.2 percent per year.[6]

Conversely, a patient who has chest pain slightly atypical for angina and yet has undiagnosed coronary atherosclerotic heart disease may be the one treated for hiatal hernia and sent home only to die suddenly at home. A diagnosis should be made by arteriography or other means if there is any significant suspicion of coronary disease. Over one-half of the deaths from coronary atherosclerosis occur suddenly. The patient's reluctance to seek medical help is the single most important factor in the five to six hour delay in hospitalization following the onset of myocardial infarction. Once the patient and physician know that they are dealing with coronary atherosclerosis, educational discussion of when to come to the hospital may shorten this delay. Once the degree of coronary atherosclerosis is defined by coronary angiography, a physician can move rationally, plan therapeutic maneuvers to control the angina and allow the patient maximum activity within the constraints of his coronary disease. Single vessel disease, especially in the right coronary or circumflex, carries a relatively good prognosis (less than 2 percent mortality/year),[6] and can usually be treated medically. Two or three vessel coronary disease is more ominous (mortality of 4 and 10 percent/year respectively).[7] A person with this degree of coronary atherosclerosis must be observed much more closely and treated vigorously, with consideration given to coronary bypass surgery.

Patients with classical angina are no diagnostic problem. Patients with chest pain with no characteristics of angina rarely have abnormal coronary arteriograms. Those with chest pain with some of the features of angina often present a diagnostic and therapeutic problem and every method available should be used to clarify the diagnosis. The methods to identify coronary atherosclerosis and musculo-skeletal pain

have been discussed in this paper. Those used to diagnose gastrointestinal causes of chest pain will be the subject of another paper. ■

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Opportunities for Continuing Medical Education

SOUTHERN MEDICAL ASSOCIATION
70th Annual Scientific Meeting
Nov. 7-10, 1976
New Orleans, La.
Category I Credit
Contact: Southern Medical Association, 2601 Highland Ave., Birmingham, Ala. 35205

AMERICAN ACADEMY OF FAMILY PHYSICIANS
Nov. 10-14, 1976
Atlanta, Ga.
Category I Credit
Contact: Camille Day, (404) 321-7445

AMERICAN HEART ASSOCIATION
Nov. 15-18, 1976
Miami, Fla.
Category I Credit
Contact: (404) 261-2260

INTERSTATE SCIENTIFIC ASSEMBLY: Major Emphasis—Family Practice, Internal Medicine, Ob-Gyn, and Psychiatry
Nov. 15-18, 1976
Atlanta, Ga.
Category I Credit
Contact: Alton Ochsner, M.D., P.O. Box 1109, Madison, Wisc. 53701

MAG SCIENTIFIC ASSEMBLY
Nov. 19-20, 1976
Atlanta, Ga.
Contact: Stephen L. Daniel, Ph.D., (404) 876-7535

GEORGIA STATE OBSTETRICAL AND GYNECOLOGICAL SOCIETY AND SOUTH CAROLINA OB-GYN SOCIETY—FALL MEETING
Dec. 1-5, 1976
Point Clear, Ala.
Contact: Chester Lane, (404) 659-0289

AMA CLINICAL CONVENTION
Dec. 4-8, 1976
Philadelphia Convention Center, Philadelphia, Pa.
Contact: AMA Dept. of Scientific Assembly, 535 N. Dearborn St., Chicago, Ill. 60610

AMERICAN ACADEMY OF PSYCHOANALYSIS
Dec. 5-7, 1976
Atlanta
Contact: V. J. Teichner, M.D., 40 Gramercy Park N., New York, N.Y. 10010

SOUTHERN SURGICAL ASSOCIATION
Dec. 6-8, 1976
The Breakers, Palm Beach, Fla.
Contact: W. D. Warren, M.D., Emory Univ. School of Medicine, Atlanta, Ga. 30322

CLINICAL PSYCHIATRY
Dec. 9-10, 1976
Augusta, Ga.
Contact: Division of Continuing Education, Medical College of Georgia, Augusta, Ga., (404) 828-3967

Conflict of Interest and the Board of Human Resources

SCOTT KILLINGSWORTH, *Atlanta**

THE STATE ATTORNEY GENERAL'S recent determination that members of the Georgia Board of Human Resources may not also be Medicaid providers because of a potential conflict of interest has produced the resignation of some members of the Board, the suspension of other members' Medicaid practice, a lawsuit, and general confusion as to what constitutes a forbidden "conflict of interest." Not surprisingly, more is at stake than the simple application of a statute to known facts: any final resolution of this controversy will necessarily involve determinations—by the courts, the legislature, or both—of the relative importance of a number of competing public policies.

The Board of Human Resources was created in 1972 to "establish the general policy to be followed by the Department of Human Resources,"[1] the State agency which administers the Medicaid program. The law requires that seven of the 15 board members be engaged professionally in rendering health services and that five of those seven be licensed to practice medicine.[2] One function the Board performs is determining the amount of reimbursement the Medicaid program will provide for various medical services.

In order to participate in the Medicaid program the Board has required physicians to sign a "Provider Agreement," by which they agree to accept the amounts of reimbursement set by the Board.

Prohibited Transaction

A Georgia statute[3] provides that "No person who is a member of any State board . . . shall engage in any transaction with any such board . . . on which such person is a member." The Attorney General contends that receipt of Medicaid reimbursement by a Board member is a "transaction" prohibited by this law: that the Board's power to set reimbursement levels, to transfer funds from other social programs to Medicaid, and to determine what services are reimbursable creates the possibility that such a Board member's perception of the public interest could be influenced by his own pecuniary interest in receiving Medicaid funds. Accordingly the Attorney General gave such Board members the choice of resigning their positions, giving up their Medicaid practices, or facing prosecution.

It is important to note that no Board member has been accused of attempting to enrich himself at State expense or of otherwise acting in bad faith towards the public. According to the Attorney General, the purpose of the "conflict of interest" law is not merely to prevent official corruption, but also to eliminate any possible temptation or opportunity for such misdeeds, and to ensure confidence in the im-

* Prepared at the request of The Medical Association of Georgia. Mr. Killingsworth is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

partiality of public officials by eliminating even the appearance that such temptation may exist. By this analysis, the actual impartiality and honesty of an official whose private interests appear inconsistent with his public duty is entirely irrelevant.

Lawsuit Debates Ruling

One Board member, Dr. Ben S. Anderson, has instituted a lawsuit on behalf of black physicians in Georgia and other Georgia physicians who provide Medicaid services and who are or may become members of the Board, in an attempt to enjoin enforcement of the conflict of interest law against such physicians. Dr. Anderson is the only black physician on the Board, and he has stopped billing the State for Medicaid reimbursement in order to remain on the Board. He contends that the benefits a Board member could receive under Medicaid are the same as any other Medicaid provider receives and, therefore, that his interest in such payments is not sufficiently "personal" to come within the statute's prohibition. He also contends that the Medicaid laws and a statute concerning the sale of services to the State by members of State boards[4] authorize the transactions in question. Finally, Dr. Anderson argues that application of the conflict of interest statute to him and other physicians similarly situated would contravene public policy by making it nearly impossible to staff the Board as provided by law and by denying the impoverished recipients of Medicaid any representation on the Board.

In resolving the issues raised by Dr. Anderson, the courts will face the difficult task of reconciling the need for public faith in the impartiality of government officials with the need for participation in the Medicaid decision-making process by those most familiar with the problems of Medicaid clients and of the physicians who serve those clients. ■

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2. Ibid.
3. Acts 1956, pp. 60, 62 (Ga. Code Ann. §89-916).
4. Acts 1956, pp. 60, 61 (Ga. Code Ann. §88-915).

A Century Ago

"It is now boldly asserted that Southern civilization was a myth; that they have contributed little to literature, to science, or the arts; that they lack thoroughness in everything; and that those who do aspire to great ends must seek mental food elsewhere than at home. Shall we give countenance to this monstrous libel by permitting our own institutions to languish, nay, to perish, under the plea of hard times? We know you are poor; we also are poor. Upon your devoted heads fell the fury of a four years war; and so it did upon ours. With you we marched through snows and rains without tents, and almost without food or clothes, to find ourselves destitute, at the close of the war, of even a pocket-knife; and yet we have lived. Many times within a year we have not had a half day's supply of food for a family of eight persons; and yet we have never failed to publish the Journal.

"Let our friends strengthen our hands as they may be able, and we will put to the blush the monstrous assumptions of our enemies."

Atlanta Medical Surgical Journal, 1868.

Researched and reported by Stephen W. Gray, Ph.D., Professor of Anatomy, Emory University.

I've told this before . . . .

(Ed. note: Dr. McDaniel writes this month of an unusual church service he attended, and how a quick-thinking minister regained control of a congregation distracted by an unexpected "guest." Others wishing to contribute to this page should send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Bird in Church

IN THE YEAR of our Lord 1955 or 1956, at the old Cathedral of St. Philip, the assistant minister Canon Sam Cobb was the preacher. Now Sam was young and had the effervescence of youth. He was well beloved by young and old alike, and while Sam was not a Phillips Brooks at that early age, we all loved him very much.

In the Episcopal church the preacher stands in his pulpit on the right of the congregation. The altar is in the center some 15 or 20 feet behind the podium from which he speaks.

On the altar were flowers at each end arranged by only one group of dedicated women, "The Daughters of the King." And on the altar is "fair linen," touched and washed only by those women whom have been blessed to do such holy work. The flowers must never be thrown in the garbage can, but must be placed on the ground to wither in peace. The water from washing the fair linen must be used to water shrubs or grass or poured on the open ground, never contaminated by other waters in the sewers. The candles must be lighted and extinguished by robed acolytes or priests.

And so on this holy day, Sam was extolling the virtues of love and the damnation of non-love, and Sam was doing pretty well. We do not say "amen" in our church, but some of the faithful were nodding their heads forward up and down at times and none of the flock were yawning or noticeably gazing at their wrist watches.

And then something happened. A bird had gotten into the church and was attracted by the flowers and candlelight. He flew from one arrangement to another, perched awhile, lit on the altar and went to the other. The poor bird was frustrated and frightened and noticeably squatted on the fair linen, time after time, as birds are want to do when excited.

Now Sam sensed that he had lost the attention of the sheep. Some of the most sanctimonious women were squirming in the pews. Some of the old pillars of the church were looking at the altar and smiling. Some of the young were laughing. But the keepers of the fair linen had buried their eyes in their handkerchiefs and were tearful.

Sam finally turned around to the altar where all eyes were cast, saw the bird flittering from flower arrangement to flower arrangement, and squatting each time between the two on the fair linen. The janitor was standing partially out of view with an upraised broom.

Sam was smart. He abruptly ceased his sermon, raised up his right hand with fingers outstretched, bowed his head and said, "May God the Father, God the Son" etc., etc.

I thought later that he might have said something about the tiny bird that caused all of the commotion, but I do not know what he could have said. I do believe, however, that the little bird would have needed a modicum of God's protective love had some of the keepers of the fair linen gotten their brooms on it after viewing the altar.

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Peer Review Committee Sets Guidelines for Utilization Control of Prescribed Medication

WALTER S. DUNBAR, M.D., *Atlanta**

As fiscal agent for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), MAG has an excellent opportunity to get a total picture of patient care as claims are presented for payment. Experience in reimbursement to patients for prescription medication has revealed the need for guidelines to protect the patient and physician from potentially hazardous situations. Such situations could include either concurrent treatment by multiple physicians or patients' unwitting use of prescribed medication in a potentially dangerous manner.

Sample CHAMPUS claims were reviewed to discover where the problems were and to determine what guidelines should be established to correct them. Those auditing the claims looked primarily for the following types of situations: (1) the filling of more than six prescriptions per month per patient; (2) refills in excess of prescribed amounts; (3) different charges for refills of the same prescription; (4) a medication cost above $25 per month per patient; (5) the purchase of drugs which was not indicated as an effective treatment for the diagnosis on the claim; and (6) patient's utilization of multiple pharmacies or physicians. It was found that the most frequently abused items were codeine in various forms, Darvon, Talwin, Valium and Percodan. The diagnoses most frequently presented were depression, skeletal problems, such as arthritis, "slipped disc," etc., hypertension and headache.

The main areas of abuse were determined to be: overutilization of medication by the patient; the prescription of drugs not specific for the diagnosis; and questionable refilling practices of pharmacists.

1. *Overutilization* occurs when the patient exceeds the physician's instructions on using medication, or uses more than one physician and/or pharmacy. To counteract this problem, it was recommended that CHAMPUS notify the physicians and pharmacies of the situation and inform the patient of the action taken. Efforts will be made to prevent the patient's use of medications in harmful quantities or combinations by continuing to bring questionable situations to the attention of the physician(s) and by limiting payment to quantities specifically authorized by the physician(s) after they have been notified of the extent of overutilization. The patient, if indicated, will be urged to use only one pharmacy.

2. *Physician prescription and/or injections of items not specific for the diagnosis, i.e., the extensive use of controlled drugs for chronic and vague diagnoses.* In this case, CHAMPUS should contact the physician(s) involved, verifying diagnoses and treatment. asking why specific medication was prescribed. Extensive utilization of injectable items also would be questioned. If a satisfactory answer is obtained the claim is paid but, if unsatisfactory, appropriate peer review is requested. In addition, it will be emphasized to the physician, when indicated, that he should exercise caution in writing refills or in authorizing refills by telephone. Physicians should be encouraged to write prescriptions in the appropriate quantities for the course of treatment and to specify either "no refill" or the specific number of refills needed. He should not write "p.r.n." prescriptions for potentially habit forming items, such as certain analgesics and tranquilizers.

3. *Questionable refilling practices or pharmacists.* It is recommended that the physicians, pharmacists and patients involved be told that no payment will be authorized for prescriptions refilled prematurely. Refills of any questionable item beyond five refills and/or six months should be authorized by the physician(s). Pharmacists should be encouraged to verify telephone prescriptions if there is any doubt as to the authenticity of the caller.

These guidelines were implemented within the CHAMPUS department in March, 1975 with excellent response from physicians. In a brief detailed study of 25 cases requiring physician contact, there were four cases in which the attending physician(s) were unaware of the patient's drug utilization pattern. This number may seem small, but when projected into the total area of possible abuse, it becomes a matter of grave concern. ■

* Chairman, MAG Committee on Peer Review, 384 Peachtree St., N.E., Atlanta, Ga. 30308.

GEORGIA BAPTIST SCHEDULES HONORARY LECTURE

The annual Joseph Yampolsky Honorary Lecture of Georgia Baptist Hospital will be given in the Auditorium of the hospital at 8 p.m., Wednesday, November 10.

Speaking is William C. Roberts, M.D., Chief of the Section of Pathology of the National Heart. Lung and Blood Institute, DHEW. Dr. Robert's address is titled, "Congenital Abnormalities of the Heart Producing Functional Disturbances in Adulthood."

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Smith, Carl W., Jr., C. W. Long—Act
Univ. of Ga. Health Services, Athens 30601

SOCIETIES

Guest speaker for the **Bibb County Medical Society** annual Witman Lecture September 7 was Eugene A. Stead, M.D. of the Department of Medicine, Duke University Medical Center. Dr. Stead, whose topic was "Prognosis Replaces Diagnosis," was the dean of Emory University School of Medicine from 1942 to 1946, and is editor of *Circulation*. In August, 27 Macon area physicians turned out to help with annual football physicals for local high schools. Several physicians will be covering weekly games at the schools this season.

Nominees for positions in the **Cobb County Medical Society** have been named and will be voted upon at the November meeting: Dan B. Stephens, president; Philip Israel, president-elect; and Evans J. Nichols, secretary-treasurer. The Society will hold its annual medical/legal dinner in late October.

Members of the **DeKalb Medical Society** learned of "Conflict and Crisis in Medical Families" at the September meeting. Dr. James D. Mallory, director of the Atlanta Counseling Center, was guest speaker.

A recent membership survey on several subjects in DeKalb County shows that those responding feel MAG membership is important and that the MAG is effective. They were less certain of the importance of AMA membership and only a little more than half of the responders feel this national body is effective. Commenting on their own society the members feel their newsletter is pertinent and informative, but should not be expanded in the scope of its detail; that the Board of Trustees is representative of the membership; and that several specific efforts and involvements of the society should be continued.

PERSONALS

First District

Michaela Dynin of Savannah recently attended the 13th World Congress of Rehabilitation International in Tel Aviv, Israel. Dr. Dynin participated in the section of sex counseling for the disabled and has been invited to the panel of international specialists.

Roderick L. Guerry has been named chairman of the Department of Pathology at Candler General Hospital. Dr. Guerry joined the Candler staff in 1974 and is chairman of the Medical Advisory Committee of the Savannah Chapter of the American Red Cross.

Fourth District

An article by **Ben Okel** of Decatur, titled "How Much to Tell Others About Your Patients," appeared in the August 9 issue of *Medical Economics*.

Fifth District

J. Gordon Barrow, coordinator of the Georgia Regional Medical Program in Atlanta, has received a resolution of commendation from the deans and faculty of Emory University School of Medicine. The Emory alumnus was commended for his nine year service to GRMP, now being phased out, and for his service on the Emory medical faculty. Dr. Barrow will continue as a part time teacher and will return to the private practice of cardiology in Douglas County.

R. Carter Davis, Jr., Atlanta, has been selected by the American Society of Gastrointestinal Endoscopy to establish the Georgia Regional Endoscopic Society.

Recently elected to the Board of Governors of the American College of Anesthesiology is **Ronald W. Dunbar,** professor of anesthesiology for Emory University School of Medicine and chief of anesthesia at Emory University Hospital. The Board of Governors is comprised of 15 members who serve six-year terms and who are elected by the Board of Directors.

Eugene O. Harrison has been appointed member-at-large of the Executive Committee of the medical staff of Georgia Baptist Medical Center in Atlanta.

Seventh District

Upon retiring from the Army after 20 years service, Billy Burk has moved to Rome and will be associated with Richard W. Leigh in the Three Rivers Ob-Gyn, P.C. Dr. Burk is a graduate of the University of Texas, Southwestern Medical School.

Tenth District

Talmadge Bowden, Augusta, has been elected to the American Society for Gastrointestinal Endoscopy.

Newly elected to the Board of Directors of the American Diabetes Association is **Thomas A. Huff** of the Medical College of Georgia.

Carl Jelenko has been appointed to a two-year term on the American Board of Emergency Medicine. Dr. Jelenko serves as Director of Burn Investigation Laboratories and Burn Service at the Medical College of Georgia.

ROSTER CORRECTIONS

Gall, Henry, P.O. Box 502, Cairo 31728. Specialty should be pediatrics, not family practice.

Oran Endogan, 1678 Mulkey Road, Austell 30001, 17—Act—C. Was omitted from the roster.

Young, Raymond, Harbin Clinic, Rome 30161. Specialty should be cardiology, not internal medicine.

Alden, Herbert S. and *Cronce, Paul C.,* Suite 250, 3316 Piedmont Road, Atlanta 30305.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

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The Month in Washington

This regular monthly summary of Washington is news prepared by the Washington Office of the American Medical Association.

September is now the appointed month for the Congress to make final deposition of a great deal of unfinished health legislation. The August doldrums saw little visible Congressional action on health business. But behind closed doors much work was performed by members and staff in committee and conference meetings. However, the final shape and form of legislation such as manpower, health maintenance organizations, clinical laboratories, Indian health, variable incentive pay, and emergency medical services will not be known until the last hectic days of the 94th Congress as it rushes to adjourn and go home for the autumnal election campaigns.

MAC Drugs Program

The Maximum Allowable Cost (MAC) drug program went into effect towards the end of August with little visible activity. First signs of life will probably appear in the late fall when MAC's advisory committee will meet to consider the initial prescription drugs for the program.

Court decisions in the various counter suits, including that of the American Medical Association, are not expected anywhere in the near future.

The three-year-old brainchild of former Health, Education and Welfare Secretary Caspar Weinberger, MAC sets price ceilings on certain widely used drugs in an effort to discourage prescription of brand-name products. Physicians would have to stipulate that brand-name drugs for Medicare-Medicaid beneficiaries are medically necessary on the prescription in order to prevent the pharmacist from filling the order with the lower cost generic drug. In states with anti-substitution laws, patients would have to make up the difference in price if a brand-name is ordered.

MAC had been scheduled to go into effect four months ago, but retail druggists joined drug manufacturers and the AMA in protest, causing the four-months postponement.

In a letter to HEW Secretary David Mathews, the Pharmaceutical Manufacturers' Association said the original postponement was to resolve "confusion and opposition" surrounding MAC. "It is our observation that such hopes have not been realized, and in fact, the situation is even more chaotic today," said PMA President C. Joseph Stetler.

The AMA and PMA have a consolidated suit against MAC pending in Chicago District Court. Other litigation has been launched by the National Association of Retail Druggists (NARD), the Private Medical Care Foundation, Inc., and Congress of County Medical Societies. Citing these, along with a petition filed with HEW on July 27 by the American Pharmaceutical Association (APHA), and the "continuing concern," and "growing dissatisfaction" of many individuals and organizations, Stetler said, "there is every reason to further delay . . . the MAC program."

The MAC proposal has many controversial aspects, not the least of which is the fact that it was an administrative decision without any legislative backing in the language of the Medicare and Medicaid laws. Thus, one of the criticisms is that it represents "government by regulation" and violates the Medicare law's prohibition against interference in the practice of Medicare.

Weinberger claimed MAC would save the government $60 million a year but another former HEW Secretary, Robert Finch, disputed the claim. Finch, now a private citizen in California, said the bureaucratic cost-of-running the program would offset any possible savings. In a letter to the *Wall Street Journal* last year, Finch also argued that bioequivalency cannot be demonstrated at present. The MAC regulations pose "the key question of whether the patient receives the exact prescription the doctor ordered," he wrote.

Physicians for the most part will be affected with Medicaid patients, since there is no substantial outpatient benefit for Medicare drugs.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them.

No federal sanctions are provided for physicians who decide to write out the "medically necessary" prescription message.

Before a Maximum Allowable Cost can be established for drugs, the Food and Drug Administration must first indicate that there are no bioequivalence problems among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers. Before the MAC can be established officially it must be reviewed by a non-governmental advisory committee and published in the *Federal Register* for comment.

The regulations establish both the Pharmaceutical Reimbursement Board and the 5-member outside advisory group.

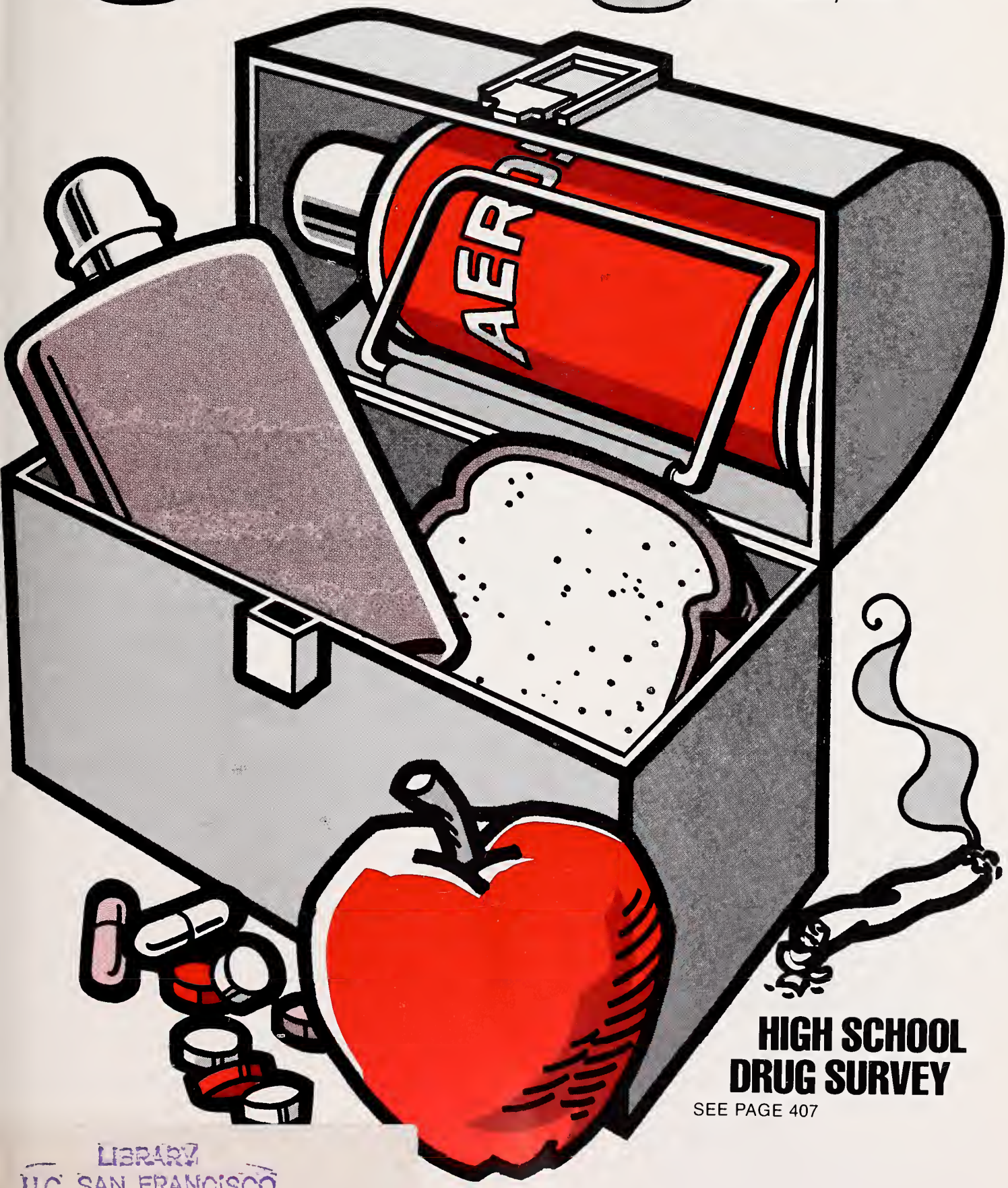
HEW said about one-fourth of commonly prescribed drugs are available from multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. Program agencies such as the state Medicaid program would make the estimates according to price information supplied on a regular basis by HEW.

Druggists protested a HEW wholesale price list designed to guide state agencies which the druggists said contained "out-of-date" low prices.

John Ball, M.D., Assistant to the Director of FDA's Office of Quality Standards, recently said it may be as

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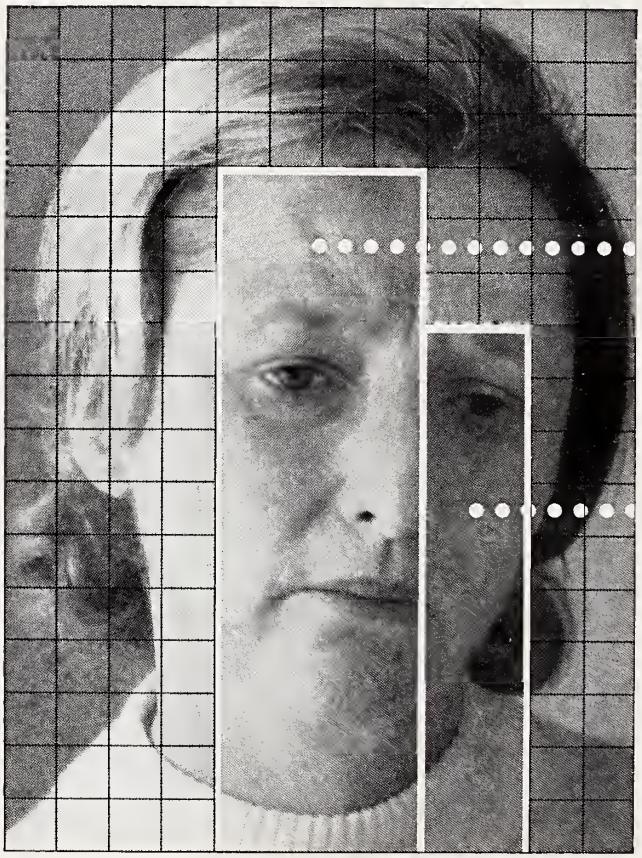


HIGH SCHOOL DRUG SURVEY

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THE COVER

The November issue features a survey of high school drug usage in a Middle Georgia county and compares its findings with those of a statewide study in 1971. Among the trends found are increased usage of alcohol, marijuana and inhalants. The recommendation is made for school officials to stress the dangers of abusing these drugs.

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High School Drug Survey, Washington County, Georgia

NOVEMBER 12, 1975

MERRILL H. EPSTEIN, M.D., CHARLES S. CRENSHAW, M.S.,
VIRGINIA M. ALBERT *and* ALLAN S. FRIEDMAN, *Atlanta**

THE WASHINGTON COUNTY Drug Abuse Council requested that the Alcohol and Drug Section of the Georgia Department of Human Resources conduct a survey of the prevalence of drug use in high school students in the county.

The small rural county is located in middle Georgia, halfway between Macon and Augusta. The population of 17,200 is about equally divided between blacks and whites. Sandersville, the county seat, is the location of the public junior high school (grades 9 and 10) and the public high school (grades 11 and 12), which serve all county students, and of a private school, Brentwood Academy, which has all grades. The public schools are racially mixed; the private school has only white students.

The county's major industries are agriculture and kaolin mining. The county was "dry" until the past two years, when it gradually became "wet."

Methods for Survey

With the cooperation and assistance of the Drug Abuse Council, we obtained permission from the superintendent of schools and the three principals to administer the questionnaires. We asked demographic questions about grade, sex, race, and head of household as well as questions about the frequency of use of specific drugs in the past year.[1] Students were instructed not to identify themselves by name or address on the forms, to assure confidentiality. Printed instructions were used by all survey administrators (the four authors) to assure uniformity of presentation of the survey.

The findings of this study may be applicable to other rural and urban areas of Georgia.

The administration of the questionnaires differed slightly in each school. In the junior high school, we read the questions over a loudspeaker to the students, who filled in the forms which had been distributed immediately before the session. In the private school, we administered the survey to each classroom separately for grades 7-12. At the public high school, because of the survey was done in the late afternoon after many students had finished classes, we were unable to visit four of the classrooms. Therefore, we had a teacher in each one administer the survey the next day, using our instructions. In all but those four classrooms, we collected and promptly removed the survey forms from the school and had the teachers leave the room or remain unobtrusive during the session, which lasted about 10 minutes.

A total of 1,284 students participated. Completion rates based on enrollment were: private school (241/251) = 96 percent; public junior high school (655/710) = 92 percent; public high school (388/624) = 62 percent.

To compare demographic variables we developed an index of drug use rates:

$$\frac{\sum_{i=1 \rightarrow 12} d_i - nu}{N},$$

d_i = number of students reporting use of drugs in one of the 12 categories,

* Dr. Epstein's address is Langley Porter Institute, University of California, 401 Parnassus Ave., San Francisco, Calif. 94143. At the time of the study, he was with the Bureau of Epidemiology of the Center for Disease Control. Mr. Crenshaw and Ms. Albert are with the Education/Prevention Unit, Alcohol and Drug Section of the Division of Mental Health and Mental Retardation, Georgia Department of Human Resources. Mr. Friedman is an Emory University student in the Governor's Internship Program.

nu = number of students who never used any of the drugs in the past year, and
N = number of students with the demographic variables being analyzed.

Alcohol and Tobacco

The drug categories included in the survey are listed in Table 1 in descending order of overall use. Alcohol and tobacco were the primary drugs used followed by marijuana and inhalants. Sleepers (hypnotic drugs other than barbiturates) were used by 7.5 percent of students overall, and the other pill categories followed. Cocaine and heroin were the drugs least used, heroin being used by only 2.6 percent of the students surveyed. A total of 265 students (21 percent of those surveyed) reported that they had not used any of the drugs listed in the past year. Table 1 shows the percent of students who reported having used drugs in each of the categories in the past year from each grade in both the private and public schools; the indices of use are also shown. The index for the entire survey sample was 1.95. The rates of drug use for students in the public schools were significantly higher than the rates for students in the private school in grades 9-12 (Chi Square = 29.3, $p < .01$). Figure 1 is a histographic display of drug use by grade.

Table 2 shows the percent of students reporting drug use for each drug category according to the demographic characteristics of sex, race, and head of household. The index of usage as defined earlier is also shown for each group. There were no significant differences between any two of the demographic variables. However, the indices were highest for 10th graders from the public school, for males, for whites, and for those with heads of household other than father. A separate comparison, not presented, showed that the groups with the highest indices were 10th-grade black males, 12th-grade black males, 11th-grade white females, and 10th-grade white males, respectively.

Table 3 is a comparison of the composite survey results for 8-12th grade students with those of a drug use survey administered to a large sample of Georgia high school students in November 1971.[2] The totals of the latter survey represent a composite from the whole state. Comparing Washington County

TABLE 2
HIGH SCHOOL DRUG SURVEY
WASHINGTON COUNTY, GEORGIA,
NOVEMBER 12, 1975
DEMOGRAPHIC CHARACTERISTICS BY PERCENT

	Male	Female	Black*	White*	Father Head of House	Not Father Head of House
Alcohol	74	67	72	71	70	71
Tobacco	66	58	62	65	62	62
Marijuana	28	22	27	25	21	30
Inhalants	23	13	19	15	17	19
Hallucinogens	10	6	8	8	7	9
Sleepers	7	8	6	10	8	7
Tranquilizers	6	6	4	12	6	6
Diet pills	6	4	4	7	5	5
Amphetamines	6	4	5	6	4	6
Barbiturates	6	3	4	6	3	6
Cocaine	6	3	5	3	4	5
Heroin	4	1	4	2	2	3
None	17	24	18	21	21	20
Index	2.2	1.7	2.0	2.1	1.9	2.1
Number	567	717	805	390	788	496

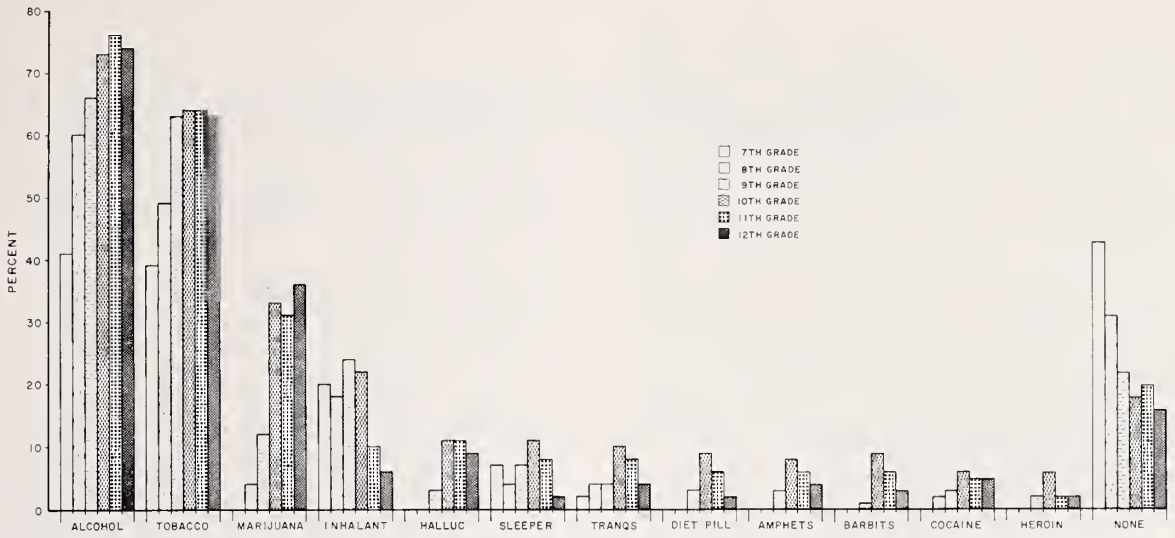
* Grades 9-12 only.

TABLE 1

HIGH SCHOOL DRUG SURVEY
WASHINGTON COUNTY, GEORGIA, NOVEMBER 12, 1975
PERCENT STUDENTS REPORTING DRUG USE IN THE PAST YEAR

	Brentwood Academy						Public Schools			
	7th	8th	9th	10th	11th	12th	9th	10th	11th	12th
Alcohol	41	60	73	68	72	70	66	73	77	75
Tobacco	39	49	68	55	57	52	62	64	65	65
Marijuana	0	4	10	16	21	18	13	35	34	39
Inhalants	20	18	12	16	6	0	26	22	11	8
Hallucinogens	0	0	0	3	6	0	4	12	12	11
Sleepers	7	4	5	6	8	4	7	12	8	2
Tranquilizers	2	4	2	10	9	4	4	10	8	3
Diet pills	0	0	5	3	6	0	2	9	7	3
Amphetamines	0	0	2	0	6	0	3	9	6	5
Barbiturates	0	0	0	3	2	0	1	9	7	3
Cocaine	0	2	0	0	0	0	3	7	6	6
Heroin	0	0	0	0	0	0	2	6	2	2
None	43	31	17	23	26	22	22	18	18	15
Index	0.7	1.1	1.6	1.6	1.6	1.3	1.7	2.5	2.2	2.1
Number	44	45	41	31	53	27	360	295	243	145

Fig. 1 HIGH SCHOOL STUDENTS REPORTING DRUG USE* IN THE PAST YEAR, BY GRADE, WASHINGTON COUNTY, GEORGIA, NOVEMBER 12, 1975



in 1975, with the State in 1971, the greatest increases in drug use were for alcohol, marijuana, and inhalants. The greatest decrease was for amphetamines. A change in tranquilizer use was not interpretable because of differences in the definitions used in the two surveys.

Patterns and Trends

An excellent response rate in two of the schools was compromised somewhat by a low response rate in the other. Apparently, the reason for the low rate was that the survey was administered in this school in the late afternoon, after many students had completed their classes for the day. We feel that the responses were generally reliable, despite the inherent problems in asking people about their illicit behavior.

Washington County is rural and not considered to be in the path of any major drug network in the state. However, the results from this survey are not necessarily representative of drug use rates for all rural Georgia high school students. Also, since teenagers who have dropped out of school have been shown to have high drug use rates, possibly higher than those of teenagers who stay in school,[3, 4] the rates from the survey are probably lower than the rates for the county's adolescents as a whole.

The rates of alcohol use, the most abused drug, increased as grade level increased to around 75 percent. A similar pattern was shown for marijuana use, the rate reaching 35 percent for the composite of 12th graders. Inhalant abuse, however, had an inverse relationship, with use rates decreasing as grade level increased. The percent of those who reported having used none of the drugs in the past year also declined with increasing grade level. None of these patterns is surprising.

The most alarming finding of the study was the high rates of use of inhalants. These are extremely toxic substances, usually containing toluene, acetone, or a fluorocarbon propellant, which may cause toxicity to the central nervous system, kidney, liver, and blood.[5] Adolescents have died from the deliberate inhalation of cleaning fluid, glue, paint and lacquer thinner, spray paint, and aerosols,[6] including spray vegetable shortening (an adolescent male in Gwinnett County and a female in Forsyth County, both in August 1974), and spray deodorant (a female in Baldwin County and a male in Cobb County, both in 1974). Many adults are unaware of this practice, and children purchase these inexpensive substances from unsuspecting retailers, despite a Georgia law prohibiting sale of inhalants to minors for the purpose of abuse. In some communities youngsters begin using inhalants by age nine, because the products are inexpensive and easy to obtain.[3] Some adolescents continue the practice into their late teenage years, while most abandon them and begin experimenting

TABLE 3

PERCENT OF 8th-12th GRADE STUDENTS REPORTING DRUG USE WASHINGTON COUNTY, GEORGIA, 1975 VS. STATE OF GEORGIA, 1971

	Washington County, 1975	Georgia, 1971
Alcohol	71	54
Tobacco	63	Not asked
Marijuana	25	14
Inhalants	18	9
Hallucinogens	8	5
Sleepers	8	Not asked
Tranquilizers	6	11
Diet pills	5	Not asked
Amphetamines	5	8
Barbiturates	4	6
Cocaine	4	4
Heroin	3	3

with alcohol and other drugs.

As adolescents acquire more money, they begin to try alcohol, tobacco, marijuana, hallucinogens, and many of the sedative-hypnotic pills. Often, alcohol and tobacco are first acquired in the home, and pills are pilfered from the medicine chest. Sleepers, tranquilizers, and diet pills were used in higher proportions by whites, especially white females, possibly because white parents receive more prescriptions for these substances than do black parents in the county. On the other hand, the rates of use of heroin and cocaine, drugs not commonly found in the home, were highest in black males, a finding consistent with patterns elsewhere.[7, 8]

In Washington County, 10th graders report the highest use rates. However, students may drop out of school after they reach 16, the age they would be in the 10th or 11th grade. If the drug use rates of those who had already dropped out of school were higher than the rates of those who remained, then the overall rates or indices for students in the 11th and 12th grades would be expected to be less than the rates for those in the 10th grade.

The differences in drug use rates from the 1971 Georgia High School Survey and from our survey are difficult to judge because the two surveys are not really comparable. Alcohol and marijuana use have been felt to be increasing yearly, but the current prevalence of inhalant abuse was not expected and poses the most serious problem for Washington County, and probably for other areas throughout the state. We suspect that more youngsters are abusing sleeping pills and tranquilizers in 1975 than in 1971, since there has been a nationwide epidemic of overprescription of these substances.[9] Heroin use rates have probably not changed; however, they represent adolescents who are experimenting rather than those who are addicted, because staying in school, almost in itself, precludes having the time necessary to become addicted, especially in a rural area where the heroin supply is limited. Nevertheless, some of these youngsters will become addicted. Hallucinogens are still popular among high school students in the state, primarily in the form of LSD and phencyclidine (PCP), which is often misrepresented as THC, the concentrated hallucinatory ingredient of marijuana. PCP is not a safe drug; it is an animal tranquilizer which has caused deaths in Georgia (a female in Ben Hill County in July 1974, and a male in Bartow County in October 1974).

Inhalant Abuse Stressed

We recommend that the Washington County Drug Abuse Council work with school administrators in teaching drug education to the students, especially stressing the danger of inhalant abuse and PCP abuse, and certainly not neglecting alcohol abuse, the most prevalent problem. Drug education must begin before the 7th grade for inhalant abuse. Local merchants should be reminded and cautioned about selling inhalants to minors. Youngsters with drug problems, either social, psychological, or medical, should be encouraged to seek help through the Drug Abuse Council. ■

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A thought-provoking review of a controversial issue.

Oral Antidiabetics: Philosophy and Politics

ANGELA J. BOWEN, M.D., *Olympia, Washington

I WANT TO ADMIT immediately that I don't know what the best treatment for diabetes is. The treatment of maturity onset diabetes has certainly never been perfect. Numerous remedies, diets and programs have been recommended through the years but the end result is never the same. In the "old days" (the '60s) . . . we knew how to do it. You sent all the patients to the school for diabetics—patient education was the watchword. They learned to test urine, weigh diets, select foodstuffs, avoid sugar, exercise, and lose weight. If that didn't work, and my files reflect that it often didn't, you prescribed one of the oral agents; which one you used was usually determined by where you had trained. If that didn't work, you used insulin. You hoped that by keeping the blood sugar as nearly normal as possible as much of the time as possible, that you could delay or prevent the vascular complications that were the inevitable end result of many years of diabetes. But our advice was always tempered with humility. We knew that we didn't really know what was best for the patient in the long run. The enthusiasm for such rigorous programs was not shared by all diabetologists. There has always been a vocal group which noted with some justification that diabetic diets were a bore, adherence usually terrible and that a little glycosuria won't kill you. So patients had a wide range of practitioners from which to choose their advice.

Thus when the UGDP study was designed and begun, it was heralded as the study that would eventually provide all the answers to the questions of when and how to treat maturity onset diabetes. Life being the way it is it should not have surprised us that quite the opposite has occurred. I do not want to discuss the UGDP study specifically, but I want to explore some of the reasons why the study has become such a bitter and lasting debate.

Oral Hypoglycemics and the FDA

There are concerns here that greatly overshadow the oral hypoglycemics and whether or how they should be used. The Food and Drug Administration has apparently chosen this study and oral hypoglycemics to implement three major changes in policy.

First, the Commissioner wants to begin to designate the "Drug of Choice" for the treatment of most major disease categories;

Second, the FDA is seeking to institute "class labeling." That is to say, if one drug of a class of similar compounds is found to have any given side effect the labels of the entire class will be changed to reflect that side effect;

Third, the Commissioner wants to act as the independent arbiter in situations where there is medical controversy.

These may at first seem esoteric points but they are realities of practical importance. One of our most precious medical heritages is the right of the physician to select what is considered to be the proper therapy for the individual patient, to make a decision based on the most widely accepted scientific information available. It is my fear, and that of many others, that this important concept is seriously threatened. Our anxieties began in 1970 when the Commissioner of FDA published in the *Federal Register* his intent to change the labeling on the oral hypoglycemics to indicate that insulin was the drug of choice for the treatment of diabetes and that oral agents could be used only when the patient was physically unable to use insulin; for example, if the patient was blind. The *Federal Register* indicated that the Commissioner would hear petitions regarding this change for 90 days. Bob Bradley* from the

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* From a talk given at the Medical College of Georgia, Dec. 5, 1975. Prepared for publication and submitted by E. D. Bransome, Jr., M.D. of Augusta. Dr. Bowen's address is 146 N. Plymouth, Olympia, Washington 98502.

Dr. Bowen and Dr. Robert Reeves were associated with the Virginia Mason Clinic and were coinvestigators in the University Group Diabetes Program until shortly before the publication of that group's first report (on the cardiovascular mortality and tolbutamide) in 1970. Both resigned from the Program rather than endorse the published results and conclusions. Since that time, Dr. Bowen has been concerned in particular with the controversy over oral agents and in general with the role of the Food and Drug Administration.

* Dr. Robert Bradley, Medical Director of the Joslin Clinic, in Boston, Massachusetts.

Joslin Clinic called me up and said in effect that we couldn't let him do this. I said, "Hell Bob! I don't care what the package insert says, I never read it anyway!" We discussed this back and forth, and it is to Bob's credit that he didn't pay any attention to my views. He must have had a phenomenal phone bill that month, for he managed to round up 182 doctors to sign a petition to the Commissioner saying that

1. We didn't agree that insulin was the drug of choice, and suggested that unless he had had some kind of divine revelation, he didn't either, and

2. That if he insisted on putting a warning in the insert, he should at least state both sides of the controversy.

We actually felt that a list of references would be adequate, in the unlikely event that there was a practicing physician in the country who had not become aware of the disagreement. He summarily rejected both suggestions. He replied to us as follows: "The FDA is required to determine the conditions of use under which the drug has been proved safe and effective by substantial evidence. This requires the FDA to act as *independent arbiter on medical issues,* and means that inevitably its decisions will not meet with unanimous scientific agreement. If an attempt is made to present both sides of a scientific controversy in the package insert, it would *overwhelm and hopelessly confuse the practicing physician. . . .*"

Alas, hopeless confusion is no stranger to the practicing physician. He or she knows it well. Though we might feel overwhelmed, most of us would still prefer to hear both sides of an issue before writing a prescription.

Resisting the FDA

Upon receipt of the above communication even I was convinced that the bureaucrats at the FDA meant business and that their business might well be legally binding on the rest of us. Since all 182 of us made our livings seeing patients, not one of us could spare the time and income to coordinate any opposition. So we did what all doctors do when they don't know what to do next . . . we called a lawyer.

The choice again is a credit to Bob Bradley; it was Neil Chayet, a bright, young, eager Boston attorney who accepted the assignment with the enthusiasm of a novice. But he certainly was not a novice. Only six days remained before the labeling change was to be effective. Chayet immediately obtained a restraining order alleging that this action by the FDA would restrict the physician's freedom to prescribe as he or she saw fit. The court was not impressed and the FDA was given the nod to proceed. At this point, an interested patient who had followed the issue in the lay press and had been switched to insulin by his physician, indicated that he would like to join in the complaint. This proved to be a critical addition. Mr. Chayet now filed another motion naming both the FDA and the Upjohn Company. He charged that the FDA's proposed package insert and the company's acquiescence presented only one side of the medical debate and therefore did not even adhere to the agency's own "fair balance" requirement. Patients moreover would be deprived of their physician's best clinical judgment.

This court *was* impressed and said in decision that "While it might be questioned that the plaintiff physicians would be harmed by the proposed labeling change there can be *no doubt* that the patients' interest is at the very heart of the matter and it is, therefore, remanded back to the FDA with more than a pious hope that a satisfactory compromise can be worked out." For more than four years, this matter has been in and out of court and hearing rooms. It has occupied untold hours of time, both legal and medical. It surprised few of us then when in contradiction of the good judges' "pious hope" that a reasonable compromise be worked out, that the FDA published an even stronger change in the *Federal Register* on July 7, 1975. The Commissioner stated that he would hear opinions, both oral and written, until September 5. He further stated that he was interested only in comments on the "specific wording" and that the actual change was specifically not to be discussed. The oral testimony was heard August 20.* There were the predictable representatives from the UGDP and the pharmaceutical houses. Mr. Nader's group was there. But I was heartened to find that there also were some practicing physicians there. In fact, the most reasoned and sensible presentation was given by a representative from one of the county medical societies in Maryland. Another, a psychiatrist, spoke extemporaneously.

I came away with the realization that the biggest problem with doctors is that they stay at home doing what they are supposed to be doing so much of the time, that other people wind up running their practices and interfering with the proper practice of medicine. Now I know first hand why that's so; I practice medicine for a living and I know how the phone rings incessantly, how there's too much paperwork and too little time. I also came away from that hearing feeling that Richard Crout† is basically an honest man trying to do a good job at the FDA. When a private physician takes the time to come up

* Dr. Bowen was one of those who testified.

† Richard Crout, M.D., Director, Bureau of Drugs, Food and Drug Administration.

and say what he or she thinks is best for the patient, Dr. Crout will listen. The FDA is seriously out of touch with the practicing physicians. In all fairness we must admit that it is our fault and not that of the FDA. We have not made the FDA aware of the problems we face out here. We have insisted that they be flexible enough to solicit our views in a manner that is compatible with our response. This will not happen. Those of us who live in the provinces and work on the front lines of patient care have come in recent years to feel somewhat abandoned by the FDA, which has appeared more and more to be taking the position that practicing physicians are not to be trusted with medications or therapeutic decisions, and that these decisions are best made by the Commissioner and transmitted directly to the patient via the wire services. If this may not actually be the position of the FDA, it is how it is perceived in the field.

We must, each one as an individual, begin to make our views known to the FDA. When those views are disregarded on critical issues, we must make that fact known to Congress. When the FDA is under attack from opportunistic politicians as it so often is, we must make our support known through those same channels. But, before we can do any of these things, we have to know what is going on; what new regulations are proposed. Someone from every county medical society in this country should be reading the *Federal Register* and if only one of you is motivated to do that, I will consider my exhortations to be worthwhile.

Two Sides of a Question

Should both sides of a medical controversy be presented to the physician? How many physicians would be willing to accept the opinion of the Commissioner of the Food and Drug Administration on a matter that his agency had under consideration, with no explanation as to how the decision had been arrived at? It will not reassure you to know that no one, and specifically no one at the FDA, has ever seen the data from the UGDP study. This is in spite of the fact that in 1971, the charge was made publicly that some statistical chicanery had occurred in that study and the numbers may have been manipulated to the advantage of one specific drug firm. It boggles my mind to think of the possible consequences if the ability to choose the drug of choice is ever solely vested in a single agency or committee, however select it might be. It has been repeatedly demonstrated that when authority is concentrated, it is much simpler to influence. With all respect to the major pharmaceutical manufacturers, they are past masters at the influence game. A federal official who had the ability to select "the" drug to be used in a given disease would be subjected to intense pressure and enticement.

Should the Physician Be Allowed to Prescribe?

Over the past couple of years, I have been privileged to represent our medical society at numerous legislative hearings. I am alternately amused and terrified as I hear professional lobbyists for consumer groups, pharmacy groups, state and federal agencies all plead the case for removing prescribing abilities from the physicians and placing them in the hands of "expert committees" as a mechanism to avoid undue influence on the physician by pharmaceutical manufacturers. It will always be more cumbersome and more difficult to influence 300,000 individual physicians than it will a committee of six, however expert. Approach advice from expert committees with great caution. They will have read the same literature that you have access to, will have studied the same pharmacology texts, and may well have less clinical experience with the drugs in question. They will certainly not have had any divine revelations.

Clinical experience and the professional literature must remain the basis for rational drug selection and use. A recent poll evaluating the various routes by which patients might receive advice about prescription drugs showed that 86 percent feel that the physician is the most reliable and least biased source of information, 10 percent chose their pharmacist, 2 percent the popular magazines, 1 percent consumer reports, and 1 percent television. Not one mentioned the Commissioner of the FDA. For as long as the practice of medicine has existed, the patient has relied on the physician for advice on drug use and selection. There are sound reasons why this liaison has endured and why it should be protected. The physician derives no profit from the medications prescribed and has only the patient's welfare to guide in drug selection. That must ever be the case. This precious prerogative must never be relinquished to "expert committees" nor the Commissioner of the FDA. But now it is under attack from all quarters. During the past year, I have heard attorneys, legislators, governors' aides, political hopefuls of all stripes, petition state legislatures and Congress to vest the privilege of drug selection in various committees, commissioners, boards, etc. The doctors were as usual in their examining rooms with patients, both completely unaware of what was about to happen to them across town.

If one set out to design a scenario that would depict the various pitfalls which would be encountered if the Commissioner of FDA were allowed to choose the drug of choice, one could not have done better than the Commissioner himself did in his choice of the first battleground: oral hypoglycemics.

Should you think labeling changes won't affect you, you might be enlightened to hear that following my testimony before the FDA on August 20, I had letters from 11 attorneys representing doctors who are being sued because they didn't use the drug as indicated in the package insert. I think most doctors have traditionally viewed the package insert as something between the FDA and the manufacturers. That used to be the case; the insert simply set advertising and marketing limits on manufacturers. Such is no longer the case.

Lest the tenor of my remarks leads you to feel that I am anti-FDA, I should state categorically that that is not the case. Practicing physicians desperately need a strong FDA. We need an FDA whose approach to drug approval and labeling is so fair as to be above reproach. We need a Commissioner who has sufficient humility to acknowledge that if the medical community doesn't agree on how to treat something, there must be a reason for it.

Other Cooperative Studies

There are now at least a dozen large cooperative studies funded by the NIH underway in this country. The master plan has been that the results of these studies will provide the foundations for the Commissioner's selection of a Drug of Choice. There are grave problems with this approach, and many have been exemplified by the UGDP. Not the least of these is the matter of who has access to the data. For example, the UGDP was a double blind study. So each investigator sent the data directly to the biostatistician, who finally was the single person ever to see all of the data. Consider the temptations for drug companies and statisticians alike. Consider the consequences for patients. Who should have access to the data? The public? The FDA? Anyone? Or no one? With the UDGP it has turned out to be No One. The raw data are in Maryland in a bank vault, protected by no less than the State Attorney General as private property.

I have no easy answer to the overall problem of cooperative studies. I simply know, having been involved with the day to day conduct of one, that I will interpret results from these studies with great caution. And I have made that recommendation to the FDA. These are basically political and philosophical considerations, far removed from what we once thought medicine would be like. But bothersome as it is, we must concern ourselves with them more than we have in the past. We must begin to challenge the appropriateness of burdensome regulations, to challenge them in the FDA, in Congress, and if necessary, in the courts. Dr. Richard Crout has said, "Remember, Congress writes the law, not the FDA. If members of the medical profession don't like it, they should go talk to their congressman." I couldn't agree more. The course of action for practicing physicians seems clear. The FDA is responsible to your Congressman and your Congressman is responsible to you and to your patients. The hour is late to remind your Congressman that YOU are the person best equipped by training, experience and position to decide which drug should be given to your patient. The charge is made frequently that doctors misuse drugs. That may be, but the least qualified practicing physician in this country is still better qualified for day to day therapeutic decisions than is the highest ranking official in the FDA.

Sometime ago I noticed a plaintive letter in the *AMA News* from Dr. Jack Keeley of Owensboro, Kentucky:

> "To the Editor: Hey out there! Somebody listen to me. I'm getting sick and tired of these restrictions on the drugs I prescribe for my patients. Sure, I know we have a drug problem in this country, but I'm not a part of it, my patients are not, and the pharmacies are not.
>
> Who is doing all this? I know it is all coming from "the government," but what are the names of the men who have this authority? Who is the man in charge and how can I get through to him to let him know my views? Somebody is making a nuisance of himself, and I'm getting tired of it, and I'm getting mad. Can anybody hear me?"

We have all shared Dr. Keeley's feelings of helplessness. But the "somebody's" name is Richard Crout. His address is: Director, Bureau of Drugs, Food and Drug Administration, 3600 Fishers Lane, Rockville, Maryland 20852. Both you and Dr. Keeley should let him hear from you. If we permit the FDA to make the critical decisions about this first class of drugs, we have lost the battle forever. No matter which side of the scientific argument you favor, all of us should join forces to protect our right to decide for our patients which, if any drug will be used. There is great danger in bypassing the traditional forum of science. There is danger in the belief that governmental authority or "official" endorsement assures scientific veracity. And there is danger in the assumption that studies at universities are beyond challenge, simply by virtue of their associations. The greatest danger of all is in relegating therapeutic decisions to a distant and unresponsive federal agency.

As a result of Dr. Bowen's testimony on August 20, 1975, the FDA has decided to audit the UGDP data. ■

Managing the Complications of Jejunoileostomy

CHARLES E. WILLS, JR., M.D., *Washington**

COMPLICATIONS OF THE jejunoileostomy bypass are difficult, frequent and recalcitrant.[1-4] Reports concerning these complications have been so frightening that many surgeons and internists have shied away from this procedure.[5-8] Investigators have advised that jejunoileostomies should be done only in large hospital environments where multispecialty help and sophisticated equipment is available. The surgery itself is not technically difficult, and could be successfully performed by most surgeons. If they were not afraid of being caught with unmanageable complications, many more surgeons would provide this procedure for needy patients in their areas. The purpose of the paper is to discuss how some of these complications have been managed. Admittedly, there have been varying degrees of success. The material is drawn from 12 years experience with 612 cases plus additional information from publications by other physicians.

Such complications as arthritis, malnutrition, electrolyte imbalance, renal calculi and febrile attacks are discussed.

Arthralgias

Swollen, migratory joint pains were seen in 35 cases. Numerous other patients complained of other vague joint pains. All patients were treated with aspirin, rest and heat. The majority of cases subsided with conservative management. Some cases recurred with lesser symptoms that patients were willing to live with.

One case was unusually severe. She was a 47-year-old widow weighing 270 pounds who had no other income except her job. Arthritic signs and symptoms occurred 19 months after jejunoileostomy. Conservative therapy was tried for 13 months. When she could no longer climb a flight of stairs which she was required to do in her job, she requested re-anastomosis. Within three months after re-anastomosis, all signs and symptoms of arthritis had disappeared. Thirteen months later, she weighed 310 pounds and was requesting the bypass again.

Excessive Malabsorption

This case history illustrates the management of malabsorption problems: 30-year-old white male, height—73 inches, weight—431 pounds. In November, 1971, an end-to-side jejunoileostomy using 14 inches of jejunum to 4 inches of terminal ileum was performed. Postoperatively, rapid weight loss ensued until, 21 months later, his weight was down to 158 pounds. Mildly impaired liver function tests, abnormal liver biopsies, leg edema and electrolyte deficiencies of calcium, potassium and magnesium were seen. Intravenous electrolytes, vitamins and glucose gave temporary respite. Hyperalimentation with protein hydrolysate and dextrose (Polynute—Kit-Cutter Laboratories) through a central venous catheter also temporarily benefitted the patient on two occasions. Finally, his bypass was revised to an end-to-side jejunoileostomy using 14 inches of jejunum and 15 inches of terminal ileum. A jejunostomy feeding tube was placed in the jejunal blind loop for supplemental feeding. For the next five months he was fed decreasing amounts of high-calorie balanced liquid feeding (Insure—Ross Laboratories) through the jejunostomy tube plus his oral feedings. His weight increased to 230 pounds. After six months the jejunostomy feeding tube was removed and he stabilized at 230 pounds. Since this time he has remained healthy and well. There have been 20 months since his bypass was revised, and four years since his original bypass.

The bypass attempts to produce controlled malabsorption of fats, proteins, and carbohydrates. A potentially dangerous state arises when this malabsorption is overdone or when protein absorption is impaired, but carbohydrate absorption is adequate.[9] Fatty metamorphosis of the liver is common both before and after bypass surgery.[11] Many cases of death due to liver failure have been reported.[5, 7, 8, 11]

Renal Calculi

Forty-three cases have developed kidney stones following the bypass. Four of those had a history of renal calculi before the bypass. Renal calculi after the bypass usually involve small stones, often multiple, that frequently pass with conservative therapy.

* From the Department of Surgery of Wills Memorial Hospital, Washington. Reprints available from Dr. Wills at 121 Gordon St., Washington 30673. Presented at the Surgical Conference of Mary Hitchcock Hospital of Dartmouth Medical School in Hanover, N.H. March 13, 1976.

One case has been observed since November, 1967, with no apparent renal damage.

One case was unusual. Her bypass was performed in November, 1966, resulting in good weight loss and few side effects. In January, 1974, chronic pyelonephritis had destroyed the function of the left kidney. The kidney was removed surgically. Ten months later, two small calculi were seen in the right kidney. In December, 1974, the bypass was taken down. Intravenous urograms in January, 1975, and October, 1975, demonstrated no calculi. She is now struggling to keep her weight under control.

Electrolyte Imbalance

Deficiencies of calcium, potassium and magnesium are common occurrences postoperatively.[1, 2, 10, 11] Bypass cases must be educated and cautioned concerning recognition of these problems. Management consists of oral supplements in lesser problems, and intravenous replacement in greater ones. In patients with hypoproteinemia and electrolyte deficiencies, correction of both problems must be treated simultaneously, since frequently success with one problem cannot be accomplished without correction of the other. In severe deficiencies replacement can be accomplished rapidly through a central venous catheter; however, this must be carefully monitored with frequent serum electrolyte determinations.

Post Bypass Febrile Attacks

Unusual recurrent febrile attacks were seen in two cases.

Fifty-three-year-old white female weighing 250 pounds had a 14-and-4-inch end-to-side jejunoileostomy in November, 1967. Following her surgery, she had recurring attacks of hyperpyrexia (temperature elevations to 105° Fahrenheit), nausea, and headache every two to four weeks for 12 months. The attacks could be relieved by intravenous glucose, narcotics, and antiemetics. Extensive studies in three different medical centers failed to demonstrate the etiology of the episodes. Her weight dropped to 160 pounds, and she was well except for the recurring febrile attacks. In November, 1968, the bypass was taken down and the episodes disappeared. She has been symptom-free for six years, but has regained all of her weight.

Fifty-four-year-old white female weighing 281 pounds had a 14-and-4-inch end-to-side jejunoileostomy for obesity in January, 1973. In May, 1973, episodes of high fever, nausea, vomiting, and headache started which could be relieved with intravenous glucose and sedatives. The episodes recurred once a month at first, but increased progressively in frequency until they were occurring every other day by October, 1973. Extensive study failed to demonstrate a cause of these febrile attacks. By this time her weight was down to 196 pounds. Her bypass was taken down and the episodes disappeared. When last contacted in May, 1974, she was symptom-free.

Comment

Hypoproteinemia is best treated by prevention.[10] This can be accomplished by checking liver profiles and evaluating the patient clinically every three months for two years, and then every six months indefinitely. The clinical picture is usually detected before the laboratory tests become abnormal. Severe anorexia, weight loss, ankle edema, and general malaise are dangerous signs, and require immediate attention. The symptom of anorexia must be relieved. In milder cases a few bottles of glucose, electrolytes and vitamins may suffice. When this treatment is unsuccessful, ten days of hyperalimentation with protein hydrolysate in 25 percent glucose with electrolytes and vitamins has produced dramatic results.[10] If this fails, or is only temporarily successful, then the bypass may be revised, leaving the patient with a longer segment of ileum. At the same time a temporary jejunostomy feeding tube should be placed in the blind jejunal loop for additional feedings until nutrition is improved and can be maintained without this supplement. If all of these methods fail, the bypass must be taken down and normal continuity of the small bowel reestablished.

Arthritic symptoms following the bypass are rarely severe enough to require more than conservative expectant therapy;[3, 10, 12] however, it appears that severe cases can be relieved by taking down the bypass. Shagrin[12] reported one similar case in a paper which excellently discusses arthritis following the bypass. Mir-Madilessi[13] reported three cases of this phenomena. Shagrin's case and Mir-Madilessi's cases had jejunocolostomies. My case had a jejunoileostomy.

Renal calculi have been reported before and after the bypass.[1, 4, 10] The case presented is the only case of its nature that I have found reported. Most cases of renal calculi can be managed conservatively; however, results on this case suggest that severe cases may be relieved by taking down the bypass.

Empirically two cases of unexplained recurrent febrile attacks were relieved by taking down the bypass. Emotional factors in both cases were suspected as the precipitating cause; however, this could not be proven. Ramas[14] suggests that febrile headache episodes relieved by intravenous glucose may be due to hypoglycemia, and may relate to cerebral edema, which may respond to intravenous mannitol. Un-

fortunately, neither of these cases were given mannitol.

Conclusions

1. More surgeons and physicians would perform and care for bypass cases if they felt confident in managing the complications.
2. Malnutrition and subsequent liver failure should be prevented by early prompt diagnosis and supplemental treatment.
3. Five cases of post-bypass arthritis have been relieved by taking the bypass down.
4. One life threatening case of renal calculi was relieved by taking down the bypass.
5. Electrolyte deficiency can be managed by supplemental replacement.
6. Two cases of recurrent febrile headache attacks were relieved by taking down the bypass.
7. Jejunoileostomy continues to produce multiple difficult problems.
8. Practically all patients who have the bypass taken down regain all of their weight.
9. Periodic long-term checking is necessary in all bypass cases. ■

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The "Doctor Bill" The Doctor Has to Pay . . .

. . . is the bill that allows full participation in the privileges and benefits of the medical federation at the county, state and national levels.

Membership in medical organizations is not just a formality, it is another way to insure that Americans can continue to enjoy the best health care system in the world.

The Medical Association of Georgia has many committees that spend thousands of hours annually on a wide variety of community health problems.

Standards of quality and high ethics are monitored and supported by organized medicine. The Association provides a pool of qualified experts to review the work of individual doctors, investigates charges of medical quackery and fraud and helps patients resolve complaints or misunderstandings about medical care.

Scientific programs help keep members abreast of medical developments and offer forums for the interchanging of ideas. Also offered are programs on socio-economic aspects of medicine and programs designed to assist office personnel in becoming more effective members of the medical care team.

So when your "doctor bill" comes, pay it promptly. It's a positive way to show your patients you are involved.

Dr. Jolley's comments, delivered October 8, 1976, express the Association's views on problems of the aged in obtaining medical services in rural areas.

Statement Before the Senate Study Committee on Services for the Aged

FLEMING L. JOLLEY, M.D., *Atlanta**

THANK YOU, Lt. Governor Miller, for giving the Medical Association of Georgia this opportunity to meet with your Senate Study Committee on Services for the Aged.

My name is Fleming L. Jolley and I am in the practice of neurosurgery at Emory University Clinic. It is my privilege to serve as the President of the Medical Association of Georgia.

My remarks today will be primarily directed at the problems doctors in our state have had in dealing with the Medicaid Program. This in turn has resulted in some areas of our state not having available to Medicaid eligible patients, including the elderly, the services of physicians. In addition, I would like to briefly touch upon suggestions for improving or adding service for our elderly.

Let me begin by advising you that the lawsuit filed by the MAG has been settled out of court. We are currently negotiating with the state on the guidelines, policies and reimbursement procedures for the Program. We are hopeful that those meetings will result in a finished document that will be acceptable to physicians and one under which we will be able to participate fully in Medicaid. In order to understand the MAG position in our suit and our current posture in the negotiations, I will briefly outline some of the issues that were raised.

The original provider agreement was very one-sided—solely to the benefit of the State and to the disadvantage of the physician. By requiring that the physician agree to adhere to the Program Manual, Medicaid usurped the physician's right to determine his patient's treatment and imposed the state's dictates on patient care. The participating physician was bound by the provider agreement to accept low reimbursement as payment in full as well as requiring him to agree in advance to factoring and a total denial of payment if funds ran out. Medicaid restricted the physician's ability to treat a Medicaid eligible patient as a private patient if he or she wished to do so. Rather than bringing the Medicaid recipient into the main stream of patient care, these program changes resulted in the State establishing second class medical care for the poor. Beside restricting the physician's right in the provider agreement, the Medicaid Program issued a Manual which was a gross interference into the practice of medicine and the physician-patient relationship.

State's Cookbook

We looked upon the Manual as the State's cookbook for medical practice—over-riding the physician's best judgment and substituting its own. The Manual required prior approval to be obtained from the Medicaid staff before certain procedures could be performed. Services were restricted by an arbitrary imposition on the maximum number of office visits and other physician-patient encounters that could be reimbursed in one month. Rather than encourage physician participation by allowing supplementation of physician reimbursement by third party insurors, Medicaid restricted the physician's ability to collect a portion of his fee from the patient's private insurance, when such was available. One of the most objectionable sections in the Manual dealt with the so-called "prudent buyer" concept. In essence, this section restricted the physician to providing the least expensive treatment now, regardless of what the cost of treatment might be over time or in the long run. Again, another effort by the bureaucrats to impose their judgment over that of the physician. Another interference into medical practice revolved around the use of the doctor's assistants—nurses, P.A.'s, medical technicians, etc. Modern medical practice demands the most efficient use of the physician's time and so a resultant dependence on his

* President, Medical Association of Georgia. Dr. Jolley's office is at the Emory University Clinic, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

assistants. The Medicaid program insisted that only services provided under the doctor's *direct* supervision could be reimbursed. Another step backward by the bureaucrats. These are the basic objections the MAG had to the Manual. Of importance to you as well as to us is a more practical, down to earth pocket-book problem that developed.

Payment Delays

For the past two years there have been increasing delays in payments to physicians and other providers by Medicaid. Routine delay in payment might be four to six months. Some claims were paid a year or more after submission. Some claims were never paid *at all*. Through the imposition of a federal regulation on a two-year limit on payment of claims, Medicaid was able to deny hundreds, perhaps thousands, of claims that were delayed, misplaced or lost by the state in its mismanaged processing. Of particular interest to this committee will be the situation which currently exists on payment of claims for the elderly who are covered by both Medicare and Medicaid. Medicaid has *not* paid any of these claims since December, 1975. For nine months now physicians have not received the fees owed them by the state. I cannot believe that such a manner of conduct in a state agency dealing with contractors would be allowed to exist anywhere else in state Government.

You might well ask how the Medicaid officials responded to this situation. Well, they were very apologetic. They blamed the computer. They blamed federal regulations. They blamed the state merit system. And after everyone was asked to share the blame, the physicians were stuck with the bill. Our services, provided in good faith to our patients, went unpaid. Individual physicians contacting the Medicaid office have been treated with a callous disregard which is inconceivable in individuals who are purportedly public servants. Our inquiries have been disregarded—our letters unanswered. In short, we were given the classic run-around.

What does all this mean on a practical basis? Angry doctors dropping out of Medicaid? Yes! But more importantly it has meant in some areas of our state inconvenience and worse to Medicaid patients. When the physician knows that he won't be paid in full, possibly not paid at all by the state, he will be reluctant to commit his time to Medicaid patients. The vast majority of our doctors are very busy practitioners. They have more than enough of private patients to handle. They can very easily fill their appointment book with these rather than Medicaid patients. Certainly our physicians still feel a commitment to providing charity care. A great many of our members continued to see Medicaid patients without signing the provider agreement and thus losing any chance of receiving payment. However, the physician, just as anyone else in our society, has an obligation to earn a living and so he must set his priorities accordingly.

Hopeful News

That has been the bad news, now let me give you some better news. The MAG is negotiating with the State on the guidelines for the Medicaid Program. We are very hopeful that these meetings will result in changes in Medicaid that will make the program more acceptable to physicians. I should caution you, however, that unless such change does occur, it is quite likely that even fewer physicians will become involved in Medicaid.

Now, let me make some suggestions to you outside of the context of Medicaid. Georgia desperately needs alternatives to nursing home care for our elderly population. Our older citizens should be allowed to continue their independent living habits and to do for themselves. In so doing, we know that they will live better, more productive later years than if they are institutionalized. For those unable to keep their homes, we should investigate incentives for expansion of domicillary facilities with essentially room and board features. For those who are able to remain in their own or relatives' homes, we should encourage the development of day care centers for the aged.

To assist our older citizens who wish to live at home, greater development of home health and visiting nurse services is required around the state. To assure the elderly of an adequate diet, we should look into programs like "meals on wheels" which deliver nutritious meals to the home.

Along other lines, perhaps we should look into more innovative approaches. Is licensure of facilities always in our best interest? Or could we accredit some residential facilities such as boarding homes or group homes, thus saving unnecessary expenditures for expensive changes in facilities or in new construction.

What about tax incentives to relatives who care for the elderly? We give tax breaks for a variety of reasons—some good and some questionable. Why not strengthen the family by supporting financially the elderly parent who wishes to live with his family. Wouldn't this make more sense than paying out tax dollars for nursing home care? Such ideas may not be feasible at the state level, but I believe our federal tax dollars could also be better spent in this way.

Lt. Governor, members of the committee, again I thank you for this opportunity to testify. I offer you the assistance of the MAG's resources to work with you in this important area. ■

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A Recurrent Bone Tumor

F. MAYNARD THAMES, JR., M.D., DAVID HANES, M.D., *and* AYTEN SOMEREN, M.D., *Atlanta**

DR. F. MAYNARD THAMES: This is the case of a 50-year-old female with pain in the left shoulder and upper arm with noticeable swelling. She presented with the same complaints 11 months ago and had radiographs of this shoulder, which are not available, demonstrating a benign appearing lesion of cystic nature in the proximal humerus, compatible with enchondroma, fibrous dysplasia, or giant cell tumor. Six months ago, the patient underwent curettement of the lesion with placement of bone chips within the lesion. Tissues submitted to pathology from that procedure was said to be consistent with enchondroma. This is a radiograph of the left shoulder made six months after the surgery (Figure 1).

Dr. Hanes, will you comment on these x-rays, keeping in mind that some bone chips were placed within the lesion at the time of curettement?

Dr. David Hanes: Although the pathology report six months earlier was reported as demonstrating an enchondroma, a benign lesion, these radiographs demonstrate some of the changes associated with a malignant neoplasm of bone: (1) the bony cortex is broken through and distorted, (2) there is some suggestion of adjacent, deep soft tissue swelling, (3) there is some amorphous periosteal reaction with an attempt to organize, (4) there is increasing density of the soft tissues immediately adjacent to the lesion suggesting soft tissue calcification, (5) there is a wide zone of transition between the normal bone and the lesion.

This could represent an infectious process, however, I strongly favor malignancy for the reasons just mentioned. Metastatic lesions to bone are the most prevalent type of bone neoplasm, this should be considered.

Dr. Thames: A recent bone scan shows no evidence of other abnormal foci within the skeleton.

Dr. Hanes: This finding would make it less likely that this is a metastatic lesion. Since this lesion arises at the site of the proximal humeral epiphysis, one would seriously consider chondroblastoma and chondrosarcoma. Since chondroblastoma has a low incidence over the age of 25, chondrosarcoma should be the more likely diagnosis on the basis of age alone for this age group, if multiple myeloma is



FIGURE 1

Radiograph of left shoulder demonstrating characteristics of malignant bone tumor in the proximal humerus.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Drs. J. L. Clements and H. S. Weens. Drs. Thames and Hanes are from the Department of Radiology and Dr. Someren is from the Department of Pathology of Emory.

excluded. Chondrosarcomas may be very difficult to differentiate from their benign counterpart, enchondromata and chondromata, for both the radiologist and the pathologist. At this point, I favor the diagnosis of chondrosarcoma arising from a formerly diagnosed benign appearing enchondroma, a relatively uncommon occurrence.

Dr. Thames: A second biopsy was performed which included a portion of the joint capsule. Histologically, the removed tissue was characteristic of chondrosarcoma. The chest x-ray was negative and the patient underwent resection of the proximal humerus along with the shoulder joint with attached portions of the scapula.

Pathology Findings

Dr. Someren, would you comment on the pathology findings on the excised tumor?

Dr. Ayten Someren: On sectioning, the humeral head was found to be replaced by grayish tan cartilagineous tumor mass measuring 10 cm. in largest diameter. On serial sectioning, areas of necrosis, cystic degeneration and focal hemorrhage were also seen. The lesion eroded the cortical bone and extended into the surrounding soft tissues in an expansile manner. There was also extension into the joint space.

Microscopically, the lesion was composed of cartilagineous tissue with scattered abnormal nuclei, larger than normal, with slight irregularity in their size and shape. These findings, however, were more prominent on some sections of the lesion and were variable.

The lesion represents a moderately well differentiated chondrosarcoma with extension into the joint space and surrounding soft tissue. The resection margin of the lower humerus was free of tumor. Previous biopsy material was also reviewed and in focal areas showed histological features similar to those described in the excised surgical specimen.

It is the feeling of most authors that the majority of chondrosarcomas arise de-novo in bone. Henderson and Dahlin reviewed 288 cases of chondrosarcoma; 36 were considered to have arisen in pre-existing benign lesions, the most common being cartilagineous exostosis. In most instances, it is difficult to trace development of a malignant cartilagineous tumor from a pre-existing cartilagineous lesion, unless biopsies have been taken at intervals. Leede and associates, however, have a contrasting opinion. These authors have observed that 19 of 45 chondrosarcomas were accompanied by other recognizable lesions including chondromyxoid fibroma, solitary enchondroma, enchondromatosis, osteochondroma, fibrous dysplasia, osteochondramatosis, and Paget's disease.

Patients with hereditary exostosis and enchondromatosis (Ollier's disease) on the other hand, are highly susceptible to development of chondrosarcoma. Often, pre-existing lesions have been present for years and clinically one of these begins to grow and become painful.

Any instance concerning the origin of chondrosarcoma from a pre-existing benign neoplasm therefore must be based on clinical history, serial x-rays, sequential biopsy and/or findings of a benign portion in the excised sarcoma.

Comment

The incidence of malignant transformation of a solitary benign enchondroma to a malignant chondrosarcoma is very low and no statistically valid data has been published. Dahlin in referring to the Mayo Clinic statistics stated that 17 of a group of 35 secondary chondrosarcomas had initially had chondromas or enchondromas. In patients with multiple familial exostosis the malignant transformation to the peripheral type of chondrosarcomas is quite high, with the more proximal lesions having the high rate of malignant transformation. Enchondromata occurring in the hands and feet have the highest predilection for malignant transformation.

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The Privacy Act and Social Security Disability

The Privacy Act of 1974 became effective on September 27, 1975. Since physicians in Georgia supply vital information to the Social Security Administration to determine eligibilty for disability and/or supplemental security income (formerly Department of Public Welfare assistance), it would help the physician to understand how the Act applies to social security disability cases.

In general, the Privacy Act reaffirms the confidentiality of social security records, while instituting changes related to an individual's right to all records about him including medical records and the right to request correction or amendments of the record. The amendment may take the form of corrections of inaccurate information, removal of items of information which are no longer relevant or timely, or the addition of information to supplement incomplete information. To date, requests for corrections or amendments have been infrequent.

In view of the confidential nature of such information, the request and authorization must be in writing, signed and dated by the individual.

Representative Assigned

Upon request for disclosure of medical information, the individual will be asked to designate in writing a representative through whom medical records may be disclosed. Such a representative should be willing to receive medical information and to discuss it with the individual.

It is anticipated that in practically all cases, this individual will be the applicant's private physician. However, a non-medical representative may be designated. The medical records will be received by an official in the employ of the Social Security Administration to determine that direct disclosure of this information will not be likely to have an adverse effect upon the individual. If the reviewing official should determine that direct disclosure of the medical information would be likely to have an adverse effect on an individual, or it cannot be determined by reviewing the records that direct disclosure may have an adverse effect, the medical information will be sent to the designated representative rather than the individual.

The number of requests from individuals to inspect medical reports obtained in connection with their disability claim is relatively small. In a great majority of requests the individual will already be aware of much of the information in his medical record.

No Confidentiality

Another change regards confidential or restricted information. No pledge of confidentiality may be given to the third party, including medical sources providing information to the Social Security Administration about the individual except in investigative and possible fraud situations. Therefore, medical information should not be forwarded to the Social Security Administration with restrictions or "confidential" annotations.

The new disclosure of information provisions do not change the way physicians should complete medical reports in connection with the patient's disability claim. As always, the emphasis is on the type objective reporting—that is, symptoms, signs, and laboratory findings relating to the patient's condition that is required for impartial disability determination under both programs. It is important to include pertinent negative findings as well as positive findings in the report. If certain laboratory proceedings or x-rays are deemed advisable, but are not available, a statement of this fact would be helpful regarding further evaluation.

The medical report should be sufficiently complete so that medical consultants can draw a firm conclusion from the positive findings to determine whether the individual meets the requirements for disability as set forth in the Social Security Act. Although the treating physician may not always agree with the decision, it must be realized that requirements are set by law and all the Social Security Administration can do is follow the law as passed by Congress. Since the decision of disability is based on objective medical evidence only, and not opinion, the physician should refrain from stating opinions in the report. The reporting physician should keep in mind that not only are opinions not a basis for determinations, but, should the individual request a copy of medical evidence used to prepare the decision in a case, the opinion included in the report will be part of the information released.

In this brief article, we have discussed the major changes in the Social Security Disability Program brought about by the Privacy Act and restated the important underlying principles of the disability program. The importance of prompt, complete medical reports cannot be overemphasized.

With prompt, complete medical reports initially, the necessity of recontacting the physician and utilizing his or her valuable time obtaining additional information can be eliminated. Although completing these reports does place additional demands on a busy physician's time, the treating physicians continued cooperation aids in prompting prompt and hopefully fair claims.

Richard H. Smoot, M.D.
Disability Adjudication Section
Division of Vocational Rehabilitation
Georgia Department of Human Resources

editorials
editorials
editorials

Dear Doctor—Please Take This Home to Your Spouse

HOW MANY TIMES have you read these words in journals or bulletins? How many times have you done it? Well—if you haven't been doing it, please start with this issue.

The Editors of the **JMAG** have been kind enough to reprint the President's Page from the Fall Issue of the state auxiliary's newsletter, **Pulse Line.** If your spouse (yes, we do have male members) is not an auxiliary member, this newsletter does not go to your home. It may well be that both of you will realize that what we are doing is important to you, to your spouse, your family and to medicine.

We would like to have all doctors' spouses join us in our efforts and this is a special invitation to those who are not members to be a part of our group, either through membership in an organized county auxiliary or as a member-at-large. Please let us hear from you!

Mrs. Milton F. Bryant, Jr.
President, Auxiliary to the
Medical Association of Georgia

BASICALLY BRYANT . . .

The Health Education Situation

"The major threats to life and health in this country have changed since 1900 from communicable diseases to chronic degenerative diseases and accidents.

"Chronic degenerative diseases and accidents are intimately related to patterns of living learned throughout life.

"Future advances in health of the public will require educating them into patterns of living that are known to discourage the onset of chronic degenerative diseases and accidents."

It was in this manner that I introduced Dr. Elizabeth K. Adams, State Health Education Chairman, who was in charge of our panel discussion, "The Need for Health Education," at the Summer Executive Board meeting. Even though the discussion ran into overtime, attention never lagged for it was obvious that here we had a group of men well-versed in their varied fields, who were speaking to us as intelligent human beings concerned about the ways in which to approach a formidable health problem.

Following recess of the meeting, members of the panel and other deeply interested individuals sat and talked for a long time. A whispered remark was, "They needed to get together." My thought is that we need to get together, too. This is beginning to happen!

What have been some of the early reactions to the meeting? First came a phone call from Sandra Owen of the Georgia Heart Association triggered

by our safety seminar featuring cardiopulmonary resuscitation. We talked for the better part of a morning in her office, discussing the Heart Association's well-planned effort to introduce in pilot programs throughout the state an authoritative study guide for teachers in health education. This is carefully constructed to reach the parents also through home discussions and projects initiated by the students. I urge you to call your local heart unit for more information on this program. Governor George Busbee's Georgia Women's Forum has invited the auxiliary to attend a series of meetings throughout the state in order to express the concerns and priorities with which we are concerned. This could allow us a small "soapbox" from which to give imput on health education. Another response came in the way of a letter from Nicholas E. Davies, M.D., Chairman, MAG Education Committee and Stephen L. Daniel, Ph.D., Director of Education for MAG. The letter stated that the Auxiliary to the MAG is beginning to take important strides forward in the area of health education and asked that we work with MAG in its commitment to this area. As a result, a letter from MAG was sent to each member attending the Summer Executive Board meeting asking for help and cooperation, and giving four distinct areas in which auxiliary members can be of assistance *now*. If you are not among those who received the letter, I am certain you may get one by writing Dr. Stephen L. Daniel, Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309. In the many kind letters and phone calls from auxilians, word is reaching us about local auxiliary action. I quote from a Tift County Auxiliary communication. "It has been determined that our state is faced with disease patterns largely in which the individual must exercise some sort of control over his daily life and environment if he or she is to ward off diseases. . . . We want to join our state in the new fight for better health and we plan to center our year's work on this general theme." There are others that have come in and it is hoped there will be more now that our work has begun to get moving.

Many Organizations Are Concerned

Many organizations and agencies are concerned about the health education situation. The AMA states, "The primary purpose of health education is to help people establish patterns of living that will discourage disease and enhance health, thus improving the quality of life." The Georgia PTA has a Comprehensive Health Committee with a well-planned program and is working throughout the state. The Cancer Society is concerned and working; the Georgia Lung Association is concerned and working; the Center for Disease Control is concerned and working—as are many more.

Let us continue with public health education programs as we have done for many years. Let us look closely at the programs being devised and already in action around our state and our nation so that we may learn. We must make use of the work already in progress and assist in the areas in which we can be most effective in our own communities. In this we will have guidance and encouragement from the Medical Association of Georgia as we educate ourselves and the citizens of our state.

Joseph Henry's words express better than mine what we are all working toward. "Knowledge should not be viewed as existing in isolated parts but as a whole, each portion of which throws light on the other . . . the tendency of all is to improve the human mind . . . for they all contribute to sweeten, to adorn, and to embellish life." Isn't this what we mean by the quality of life?

president's letter

Beeper on His Belly



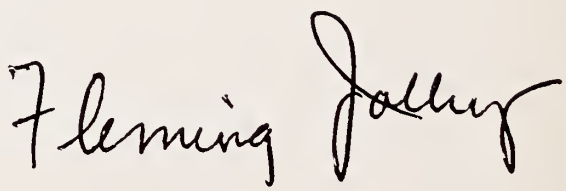
OVERHEAD DURING a recent dinner with Anne was this description of a physician: "How true it is that one seldom sees the physician without his beeper attached to some article of clothing."

Unfortunately, the comments were not complimentary by the physician of his colleague and, yes, the remarks could be heard at some distance among the laity. His "beef" was directed to physicians in political activities seemingly at the expense of patient care.

This type of public relations equals the elevator and hall conversations by physicians whose comments are overheard. No wonder the public image of physicians has declined.

The "gold plated stethoscope" and the "Medicaid mills," etc. have really helped. Rupert Bramblett sent along some distracting letters to the editor and cartoons from newspapers recently. His plea is a good one. Where are our patients' letters giving good P.R.? Why don't we encourage our patients to defend us with some letters to the editors?

Ah! November . . . Thanksgiving. Yes, there are many things for which we can be thankful. Let's try a little harder.



Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Review of Hypertension and Hypercholesterolemia in Children

Part 1

KENNETH J. DOOLEY, M.D., *Atlanta**

HYPERTENSION HAS, for years, been one of the leading crippling diseases of this country. Until recently, essential hypertension in children has been thought to be a rare occurrence. For years, we have all been taught that hypertension in children is a secondary disorder and a thorough work-up would lead one to the proper diagnosis and appropriate therapy. With careful follow-up and the increased emphasis on early detection of hypertension, the statistics are now revealing a larger number of children with essential or primary hypertension. The familial occurrence of hypertension, the high incidence of cerebrovascular disease, myocardial damage and renal disease in the adult population should prompt us to be more thorough in our examination of children, especially with reference to obtaining a blood pressure recording, when a history of the above problems is obtained in the family.

Measurement Technique Important

There has been much debate as to what the hypertension levels in children are and are we justified in applying the criteria for adult hypertension in children. In measurement of blood pressure in children, the technique used is very important. It is essential that the blood pressure cuff cover ⅔ the arm between the elbow and shoulder and that the rubber bladder which is inflated have the capacity to compress ⅔ of the circumference of the arm. A blood pressure cuff which is too small will give spuriously high readings. The second component is that of auscultation. Few people have any problem recognizing the first sound of the systolic measurement but there can be great confusion in determining the diastolic reading. Does one record the point where the sound becomes muffled or disappears? Which reading will be the most accurate will require years of study most likely, but to take the muffling and disappearance and record both is probably the most dependable as any change which occurs leaves one with a range for comparing both, and does not leave one wondering which was used at the last examination. When one does see a patient with hypertension usually muffling and disappearance occur very closely, leaving little doubt as to the presence of diastolic hypertension. The third component is to repeat blood pressures in the same plane (i.e., supine or sitting or standing).

I must truly admit that obtaining blood pressure in infants can be a very trying procedure in a busy office practice but can often be quite helpful for later reference. With the multiple visits an infant has to a physician only for well baby checks, a

* Assistant Professor of Pediatric Cardiology of Emory University School of Medicine, 402 Glenn Memorial Building, Grady Memorial Hospital, 80 Butler St., S.E., Atlanta, Georgia 30303. Part 2 of this article will appear in the December *Journal*.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

well trained nurse or physician's assistant can undoubtedly find one visit where the child is quiet and cooperative. Beyond the age of three years there is really no excuse for not obtaining a blood pressure recording, as most children beyond this age are quite cooperative.

Ranges by Age Group

Once one has obtained the blood pressure recording, what are we going to classify as hypertension? Londe,[1] Loggie[2] and Lauer[3] have all published data in regards to evaluation of blood pressure at various ages. Loggie[2] and Lauer[3] have used the adult criteria to make the diagnosis of hypertension (i.e., over 140 mm Hg systolic and over 90 mm Hg diastolic). I would have to agree with them 100 percent, as any child with manifestations of adult hypertension can not be overlooked. Londe,[1] however, takes a different approach. By recording blood pressures during routine pediatric care he has drawn up ranges for each age group and has characterized children in the 90th-95th percentile as borderline hypertensives and those beyond the 95th percentile as hypertensives. I find this approach appealing in the fact that it gives one a group of children in whom careful follow-up is required as these children may be the hypertensives of tomorrow. With this kind of follow-up we will also learn more about its presentation, usually silent, and possibly its etiology.

Table I is a summary of pressures as presently found in the literature. The higher values for systolic and diastolic by age are the 95th percentile.

What does one do if a patient with borderline hypertension is found? As previously described, following these patients with repeated blood pressure recordings is mandatory. Londe[1] and Loggie[2] have in their series found that 35 percent of the patients become normotensive with follow-up, 50 percent remain in the borderline range and 15 percent develop definite hypertension. The normotensive group should be checked occasionally but the borderline and hypertensive group need close follow-up.

How thorough an investigation must be undertaken if true hypertension is found? What amount of time and testing should a patient be subjected to in order to determine if secondary hypertension is present? The majority of us will obtain history referrable to diabetes, allergies, and rheumatic fever, but rarely about strokes, heart attacks and hypertension. This information can be of great benefit as Londe[1] has found in his group of hypertensive patients that 54 percent had a family history of hypertension while only 9 percent of the normotensive group had a family history of hypertension.

The drug history is also significant as prednisone, ACTH, vitamin D, mercury, eye drops in infants, and licorice are known to cause hypertension. History of

TABLE I

BLOOD PRESSURE RANGES BY AGE

	Systolic	Diastolic
½-5 days (premie)	45- 60	
½-5 days (full term)	63- 80	
6-11 months	78-103	49-74
1 year	82-109	52-79
2-4 years	86-109	56-79
4-6 years	84-118	52-82
6-8 years	86-122	55-82
8-10 years	86-125	58-84
10-12 years	86-132	56-85
12-14 years	87-140	60-85
14-16 years	95-140	65-85

recurrent G.U. infection, hematuria, unexplained change in personality and/or weight, palpations, abdominal trauma, fever of unknown etiology, muscle weakness, parasthesia tetany, polyuria, polydypsia, have all been associated with causes of hypertension.

Signs found during physical examination which should lead one to investigate another cause for hypertension include heart murmur, absent or delayed leg pulses, seizures or neurological signs, ascites, edema, abdominal masses, and widened cranial sutures.

Rance et al. published a comprehensive list of the causes of hypertension in infants and children.[4] In proceeding with a work-up of secondary hypertension positive history will lead you in determining which laboratory studies to select or one may depend on most common lesions found at a specific age.

Obesity Present in Majority

Evaluation of patients found to be hypertensive is a very costly and often a fruitless search. A well defined approach to work-up has been described by Loggie[2] in 1969 in which a most complete work-up can be carried out during a five day hospitalization. Londe et al.[1] in 1971 showed in their review that obesity was present in 54 percent of their patients with hypertension and only 14 percent of his normal controls. This can be very useful information when combined with a thorough physical examination and good baseline laboratory investigation. It may help in elimination of some of the more costly and invasive techniques for evaluating renal status.

It has been known for a considerable number of years that essential hypertension is much more common in the Negro race than in the Caucasian and this fact plus the presence of obesity and a positive family history almost makes essential hypertension the diagnosis of choice.

I will not attempt in this article to go into the various modes of therapy for hypertension but Loggie,[5] Rance,[4] and Sinaiko[6] present rather comprehensive approaches to this problem. As with other aspects of hypertension, the precise amount of each medication required and what the long term effects of these drugs in children may be remains a mystery, but it is only with an organized approach to treatment in children that this information can be obtained. In view of the lack of data available in treatment, the approach one may wish to take is to allow a consultant to initiate therapy and participate in follow-up so as to make the acquisition of data as central and uniform as possible.

In conclusion, I would like to stress several points. First, we will only be able to help patients if we are aware of their problems, and part of getting to know their problems includes a good history including family history. The high incidence of hypertension and myocardial infarction within families may not be completely eradicated but we surely can reduce the incidence and the devastating sequelae with early treatment. Secondly, all children beyond the age of three should have blood pressure recorded at least once a year, especially if obesity, hypertension and myocardial infarction are present in the family. ■

Part 2 will be presented in the December Journal.

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Certificate of Need and Public Law 93-641

J. WINSTON HUFF, *Atlanta**

OVER THE YEARS a number of states have adopted what are termed "certificate of need" laws. The certificate of need laws are those laws which impose regulatory control over the construction and expansion of hospitals, nursing homes and other health care facilities and services. The approach is similar to the regulation of utilities, the test being whether the construction or expansion or service is in the public interest and is required by public convenience and necessity. If it cannot be demonstrated to the state authorities that the facility is "needed," or if it appears that the public's needs in the area are already adequately supplied, then the facility cannot be built or expanded nor the additional service provided. It makes no difference whether the proposed construction, expansion or service is public or private.

Georgia has no such law.

In years past, Congress has in several instances tied a finding of "need" to the dispensation of public funds. For example, the Hill-Burton law, which funded the construction or expansion of so many hospitals in this country, contained a provision requiring the state agency involved to conduct surveys of bedding patterns to determine the desirability of the proposed facility and to determine whether over-bedding would result.

However, the certificate of need requirements of Public Law 93-641 (National Health Planning and Resources Development Act of 1974) go beyond any heretofore seen in any federal health program. This law was designed to bring together the planning and funding functions of most federal health programs. The law supersedes Hill-Burton and governs the flow of federal funds for construction, expansion, improvement, equipment and the like. A synopsis of the entire law will be found in the March, 1975 issue of *JMAG*. This article will be confined to the certificate of need aspect.

Public Law 93-641 does not *require* a state to enact a certificate of need law, but it attempts to coerce this result by cutting off all federal health funds to a state if such a law is not adopted. The scenario goes something like this:

1. In order to receive federal funds within a state, the governor must enter into an agreement with the Secretary of Health, Education and Welfare for the designation of a "State Health Planning and Development Agency" (the "State Agency").

2. The function of the State Agency is to prepare and adopt a "State Administrative Program" (the "Program"). The law prescribes the criteria which the Program must meet and sets forth the required minimum functions of the State Agency.

3. One of the necessary functions of the State Agency is

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association. Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

". . . (B) *administer a State certificate of need program* which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary. Such program shall provide for review and determination of need prior to the time such services, facilities, and organizations are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services, facilities, and organizations found to be needed shall be offered or developed in the State. . . ." [§1523(a)(4)(B)]

4. Another requirement of the Program is that it must "contain or be supported by satisfactory evidence that the State Agency has under state law the authority to carry out [its] functions and the State Program." This pretty plainly means that a certificate of need procedure must be authorized by state law in order for the state to enter into the required agreement with HEW.

5. If, within four years of the enactment of Public Law 93-641 (1975) a state has not entered into the required agreement with HEW, it cannot obtain federal funds under that law, nor under the Public Health Service Act, the Community Mental Health Center Act, or the Comprehensive Alcohol Abuse, etc. Act of 1970, for the development, expansion or support of health resources in that state.

Thus, if Public Law 93-641 is upheld, a state will have to adopt a certificate of need program in order to get any federal health funds.

Court Suits Challenge Law

The State of North Carolina has brought suit before a three-judge federal court attacking the law and challenging the right of the federal government to withhold the grant of funds because that State does not have a certificate of need law. The AMA has intervened in the case and the State of Nebraska has asked the court for leave to intervene.

At one time, North Carolina had a certificate of need law. However, this law was challenged and the North Carolina Supreme Court declared it invalid on the ground that it violated due process of law. The court found no reasonable relationship between the right of a private person to build a hospital with his own funds on his own property, and the alleged promotion of public health, which was the purported basis of the North Carolina law. Since there was no such reasonable relation, the North Carolina Supreme Court said that the North Carolina law did not withstand the due process test.

The attack on Public Law 93-641 by the State of North Carolina is based principally on two provisions of the United States Constitution. First, Article IV, Section 4, which states that "the United States shall guarantee to every State in this Union a Republican Form of Government. . . ." The other constitutional ground, the Tenth Amendment, provides that "powers not delegated to the United States by the Constitution nor prohibited by it to the States are reserved to the States respectively, or to the people."

North Carolina contends that this attempt to force its Legislature, on pain of the loss of federal funds, to enact legislation which its own Supreme Court has declared invalid, violates the above-stated Constitutional principles. North Carolina also asserts that it would have to amend its constitution in order for the Certificate of Need legislation to be valid in that state. This, says North Carolina, is a usurpation by Congress of North Carolina's constitutional and legislative processes. At this writing, the case is pending and the court has not yet held any hearing.

The National Association of Regional Councils has filed suit in the District of Columbia challenging the Certificate of Need and other portions of this law. The State of Missouri has also brought suit in the District of Columbia seeking relief principally from portions of the proposed Regulations issued under the law. The Court has consolidated these cases for trial.

As information concerning this litigation is received it will be reported in the *Journal*. ■

I've told this before . . . .

(Ed. note: Mischievous college freshmen "capture" a circus and enjoy the unusual performance in this story by J. G. McDaniel, M.D. Others wishing to contribute to this page should send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Circus on Herty Field

IN THE YEAR of Our Lord 1921, I was a freshman at the University of Georgia in Athens. The phrase "typical freshman from a small town" fit me to a "T." The usual compliments were bestowed by the sophomores, such as all hair cut from your head, prompt obedience to reasonable requests of servitude, such as running errands, cleaning up the room, making beds, etc. We had to memorize all the Georgia songs and college yells and stand oral examinations from time to time, especially on Saturday nights. The penalty for failure was grabbing your ankles and a few licks with a belt across the backside to jog your memory.

This may sound bad, but in reality it wasn't. Most of us were from little towns, had very little money, and this was something to do, especially on weekends. Life was never monotonous; if nothing was going on, either the sophomores or freshmen usually could dream up something.

Such was the case one Saturday night. Barnum and Bailey's Circus had been in town for two days and along about 11:00 o'clock, the first wagons commenced rolling to load the circus back on the train cars that hauled it. They were not motorized in those days and the wagons of equipment were drawn by two or four big horses, and sometimes the elephants. Ofttimes it was several miles from the railroad sidetrack to the circus grounds. This could be quite a chore for the roustabouts. It was also fascinating to see and hear them handle the horses and elephants and to see the lions and tigers go by in their cages.

On this particular Saturday night, a group of students was sitting on the curb watching the wagons as they went by the campus. The subject came up as to how the drivers knew the way back to the train, especially at night. One observant student pointed out that lighted flambeaus were placed on the corner where they were to turn, then they proceeded to another flambeau, etc. If it were a long stretch of road, other flambeaus would be placed in the middle of a block to indicate they were on the correct route.

This gave one ole boy an idea. Why not get a couple of their flambeaus and put one on the corner of the small unpaved road that led into Herty Field and the other in the middle of Herty Field. Now Herty Field is flanked by dormitories and this was the only road in or out.

It was about 1:00 o'clock a.m. when there was a lull in hauling. They had finished the performance at the circus and all hands were required to take down the big tent. During this lull, the flambeau at the corner of Lumpkin Street was moved to the corner of the road entering the campus and two more were moved, one placed in the middle of the field and the other at the far end.

The first wagon to come along was two horses pulling a lion in his cage. The driver was heard to say, "Whoa, whoa." The horses stopped and he eyed this narrow unpaved road, which evidently did not seem right to him; then another wagon pulled in behind him and stopped. The first driver was heard to say, "watch these horses; I'm going to walk up this road aways." He walked around a little curve in the road and saw the two more lights in an open space. He walked back and said, "I guess this is right; I see two more 'stink pots' up ahead."

When the lead man reached the last flambeau, he could find no evidence of a

road, nor a light further on. All he could see were buildings surrounding this old football and drill field. By this time some 15-20 wagons had followed him into the cul de sac, also about 10 elephants. Lights were beginning to flash on in all the dormitories and there was much yelling and screaming about lions and elephants invading the sacred ground of Herty Field so early on Sunday morning. Someone had waked the bugler; that worthy stuck his horn out of the window and let forth every conceivable blast known to buglers.

During all this confusion, the field kept filling up until the high boss came riding in on a white horse. The roustabouts called him "Ramrod" and his looks did not belie the title. He wanted to know what "in the hell" was going on. About half a dozen drivers explained that somebody had "screwed up" the flambeaus. Ramrod stopped the wagons from coming in, ordered all wagons to turn around and then galloped off to re-establish the route.

By now most all the students were awake and yelling something about lions and tigers and elephants being on Herty Field. Someone called the police department and told them that some lions were loose on the campus. Another called the Dean and told him that the circus was pitching a tent on Herty Field and nobody could sleep because of the noise and that the students would appreciate it if he would come over and see what was going on. The old Dean called his second assistant, a man always called on to do any dirty job, such as reprimanding students, sending them home for non-attendance of classes, etc., but he enjoyed his authority. Everyone called him "Dean," which flattered him very much.

In some 20 minutes the Dean appeared and the students cheered and clapped their hands. "Now," they shouted, "we'll get some action." The lions and tigers had gotten upset and were roaming; the horses were nervous and fidgety. Drivers were swearing and having trouble turning their wagons around in the darkness.

The Dean wanted to know who the boss was and about that time "Ramrod" came riding in on his white horse. He was very much flustered and the horse, sensing his frustration, was flustered too. He was in a lather and kept prancing around. In all the commotion, the Dean had trouble getting Ramrod's attention. When he did, he identified himself and told him in no uncertain terms that this was state property and that he had no right to be there. Furthermore, he must move those ferocious animals off this property immediately so that peace and quietness could again reign on the campus this holy sabbath morning.

No one ever knew what Ramrod said to the Dean. He bent over from his saddle close to the Dean's face and spoke a few terse, short sentences. The Dean backed away slowly, turned around and came back to the students. He was pale and looked as though he had seen a ghost. He told the students very simply that Herty Field would be cleared within an hour and left.

And it was! . . . Good thing, too, because everybody was tired and sleepy and there were a few faint rays of the sun in the east.

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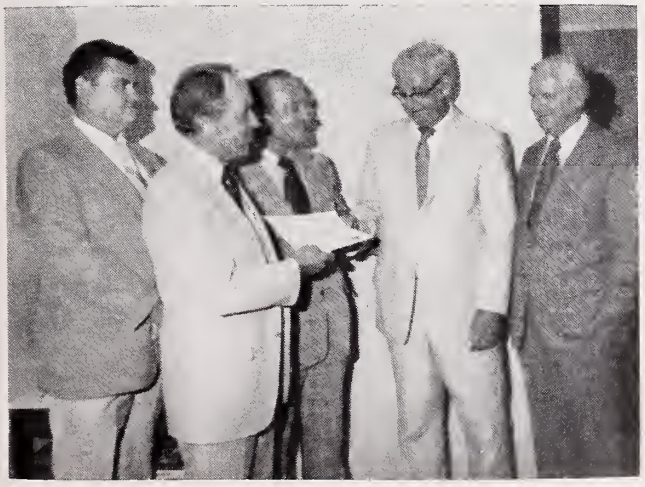
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SOCIETIES

G. Douglas Talbott, M.D. was the guest speaker for the October meeting of the **Bibb County Medical Society,** and discussed the Disabled Doctors Program for which he is chairman. Milton Johnson, now serving as MAG second vice president, has resigned his position as Bibb County councilor and will be replaced by Beverly Sanders. A new vice councilor will be elected by the society. A recent visitor to Macon was Michael E. DeBakey, heart surgeon, who spoke on "Research in Heart Disease" at a public lecture.

Guest speaker of the October meeting of the **DeKalb Medical Society** was Alton Ochsner, M.D., professor emeritus of surgery at Tulane University who spoke on "Medicine: Past, Present and Future." In November, the society will meet with the DeKalb Bar Association, and Governor George Busbee has been invited to speak. Nominations for Society officers have been presented and include: president-elect, H. Duane Blair; vice president, Charles W. McDowell, Jr.; secretary-treasurer, William Hardcastle and Ernest Fokes in opposition; MAG delegates (three positions), Stanley Aldridge, L. C. Buchanan and John Heard; alternate delegates, Hardcastle and Fokes against each other,



MAG President Fleming Jolley presents a Certificate of Accreditation in Continuing Medical Education to representatives of Georgia Baptist Medical Center (L-R): James Maughon, M.D., director of graduate and continuing medical education; Charles Scott, M.D., chairman of the Committee on Graduate and Continuing Medical Education; Edwin Peel, administrator; and Edwin Evans, M.D., chief of staff. The certificate comes from the American Medical Association in cooperation with MAG and represents the fulfillment of the requirements set forth in the Principles and Objectives of Continuing Medical Education.

Richard Mattison and David Levenson; for junior trustee, Suzie Tindall for one position and Theodore Whitson for a second. Additional nominations are expected to come from the floor when a vote on the slate is held at the December 20 meeting. Stanley P. Aldridge will be the new president.

The DeKalb Society has received a new set of cassette tapes for its Tel-Med system on hospital-related procedures. A list of tapes will be sent to each member to dispense to patients as he wishes.

The **Georgia Medical Society** sponsored a medicine and religion seminar in early October which featured as speakers Alfred A. Messer, M.D., Atlanta psychiatrist; Thomas A. Bland, Th.D., professor of Christian ethics at the Southeastern Baptist Theological Seminary in Wake Forest, N.C.; and Charlene R. Black, Ph.D. with the department of sociology and anthropology at Georgia Southern College in Statesboro.

The GMS has joined in an ecology battle to prevent a Savannah public utility from discharging polluting dusts and gases into the air. The Society has reaffirmed its commitment to clean-air standards for the area.

The **Hall County Medical Society** plans to meet with local legislators for a breakfast conference prior to the 1977 General Assembly. During the September meeting, Drs. John Aycock and Chuck Moscher of the Department of Human Resources presented a program on "Advance Cardiac Life Support."

Politically-minded **Medical Association of Atlanta** members heard a "Great Debate" between representatives for the Ford and Carter health care planning teams in October. Peter Bourne spoke for Carter, and representing Ford was Roger Egeberg of Washington, D.C., a Ford advisor.

Members soon will vote on a new slate of officers who will take office after the December meeting. The nominations include: president-elect, Charles Harrison; secretary, William B. Spearman; junior trustee, Jeffrey T. Nugent; trustee at large, Armand Hendee, and to fill the unexpired term of Charles Harrison, Frank L. Wilson and David Cole, in competition. Western district trustee, G. Fraser Williams, and southern district, B. F. Voljavec; for the judicial Council, John C. Hall. Lewis Felder is challenging John T. Godwin for his councilor position and Norman Berry hopes to succeed himself as alternate delegate. William Huger will be the new president.

South Georgia Medical Society has elected new officers for 1977: Robert Parkhurst as president; William Threlkeld, president-elect, secretary-treasurer will be Edwin Hiatt and Franklin Eldridge is the MAG delegate. During the September program, the Society members heard Stanley Winoker, an Atlanta oncologist, discussing "Adjunctive Chemotherapy."

PERSONALS

Third District

C. Daniel Cabaniss, immediate past president of the Georgia Heart Association, received a bronze presidential medallion for distinguished service at the GHA's 28th Annual Meeting in September in Savannah.

Fourth District

A paper by **William E. Silver** of Atlanta was selected for reading before the Ninth Pan-American Congress

of Otolaryngology in New Orleans in November. It was titled, "Cervical Thymic Cysts." A second paper, "Laryngeal Fractures—Diagnosis and Treatment," was selected to be read before the Southern Medical Association meeting in November.

Fifth District

Staff changes at St. Joseph's Infirmary include **Stuart Toporoff,** staff cardiologist, elected as secretary of the medical staff. **Seymour Weinberg** will replace **Sterling Jernigan** on the Executive Committee and **Bernard Lipman** replaces **Walter Dunbar.** Dr. Lipman is a consultant to the Ad Hoc Committee on EKG Interpretations sponsored by the American College of Cardiology, and was on the faculty for the course, "Electrocardiography: Core Curriculum and Self-Assessment" given in Scottsdale, Ariz., October 11-13.

Steven L. Sanders has joined the surgical staff of St. Joseph's Infirmary.

Grady Clinkscales, Jr. attended the mid-September Combined Meeting of Orthopedists in Edinburgh, Scotland, and presented a paper on "Congenital Absence of the Ulna."

Charles F. Nicol has joined the staff of Georgia Baptist Medical Center as director of the electrodiagnostic laboratory providing EEG and EMG services. Dr. Nicol comes from Buffalo, N.Y. **Eugene O. Harrison** has been appointed member-at-large of the executive committee of the medical staff. **Richard W. Abel** is

WILBER INSTALLED AS HEART ASSOCIATION PRESIDENT

Joseph A. Wilber, M.D. of Atlanta, nationally-recognized authority in high blood pressure detection and control, is the new president of the Georgia Heart Association, succeeding C. Daniel Cabaniss, M.D. of Columbus.

Nanette K. Wenger, M.D. also of Atlanta, is president-elect, slated to become the first woman president in the association's 28-year history.

Macon businessman Myer O. Sigal, vice president-controller of G. Bernd Co. and chairman of the board of Macon Bank and Trust Co., has been chosen for a third term as chairman of the board of directors of the Heart Association.

The installation of new officers and members of the board took place during GHA's Annual Meeting and Scientific Sessions at the DeSoto Hilton Hotel in Savannah in mid-September.

Dr. Wilber, who heads the state's stroke prevention program as supervisor of adult health for the Georgia Department of Human Resources, is also medical director and vice president of Georgia International Life Insurance Co. and clinical associate professor of medicine at Emory University School of Medicine.

Other new GHA officers are Charles E. Rowland, Jr. of Tucker and Joseph M. Turner, M.D. of Tifton, vice presidents; Claude Williams, Jr. of Athens, secretary; and Hilliard A. Bowen, Ph.D. of Atlanta, treasurer.

The following were elected to three-year terms on the board of directors: Nicholas E. Davies, M.D. and Bernard S. Lipman, M.D., both of Atlanta; William J. Rawls, M.D. of Decatur; Jackie Enterkin and Luther G. Fortson, M.D., both of Marietta; Ernest Bacon of Dalton; Patrick I. Fenlon of Thomasville; Heyward C. Hosch, Jr. of Gainesville; Hurley D. Jones, Jr., M.D. of Brunswick; and John P. Strelec of Augusta.

Dr. Wilber is a native of Rochester, N.Y. and graduate of Harvard Medical School. After internship and residency at Boston City Hospital in Massachusetts, he was a residency and research fellow at Grady Memorial Hospital in Atlanta and a U.S. Public Health Service research fellow in hypertension at Oxford University in England.



New officers of the Georgia Heart Association include (L-R) Joseph A. Wilber, M.D., president; Nanette K. Wenger, M.D., president-elect; Myer O. Sigal, chairman of the Board; and C. Daniel Cabaniss, immediate past president.

He received the Aven Cup from the Medical Association of Atlanta in 1975 in recognition of outstanding community service and the 1971 "Heart of the Year" award from the Georgia Heart Association.

Dr. Wenger is professor of medicine (cardiology) at Emory University School of Medicine and director of cardiac clinics at Grady Memorial Hospital. She also directs A Program for Cardiac Evaluation and Medical and Vocational Rehabilitation.

She is currently serving the American Heart Association as vice president and chairman of the program committee.

At the meeting, a special display devoted to the life and career of Eugene A. Stead, Jr., M.D., former dean of the Emory University School of Medicine, was presented to the GHA by its Historical Documentation Committee, chaired by S. Robert Lathan, M.D. of Atlanta. Dr. Stead has been at Duke University, since 1947 serving 20 years as chairman of the department of medicine and physician-in-chief at Duke Hospital.

the new director of graduate and continuing education in pediatrics.

Norman E. Jones has joined the staff at Kennestone Hospital in Marietta, and specializes in therapeutic radiology.

At a recent annual meeting in Williamsburg, Va., **Donald C. McLean** of Atlanta was named president-elect of the Southeast Allergy Association.

Sixth District

Osee F. Keen, retiring from practice after 63 years, was featured in a human interest story in the *Macon News* in October. His secretary of 43 years, Mrs. Sarah Morgan, said of him, "Dr. Keen is very kind. Lots of times his patients come in and say 'I feel better just talking to you whether I need anything or not.' He takes time to sit down and explain everything, and that's very important."

Seventh District

After practicing medicine in Douglas County 65 years, **Claude Victor VanSant, Sr.** has been awarded membership on the honorary medical staff of Douglas General Hospital.

Ninth District

Joining the staff at Hall County Hospital are **Donald R. Willers, John Darden** and **Roger Owens.** Dr. Willers is a Chicago native who was graduated from the University of Illinois Medical School. Dr. Darden was graduated from the Medical College of Georgia in 1971 and is a surgeon, while Dr. Owens will practice internal medicine. He is a graduate of Temple University Medical School.

Tenth District

Carl Jelenko of the Medical College of Georgia is president-elect of the University Association for Emergency Medical Services and chairman of the Emergency Medical Services Committee for the American College of Emergency Physicians.

A new wing of the Talmadge Memorial Hospital, which will increase the number of hospital beds from 400 to 614, was dedicated October 13 and named for a deceased MAG member Virgil P. Syndenstricker. Dr. Syndenstricker was a faculty member from 1920 until his retirement in 1957.

DEATHS

Charles K. Bush, Jr.

Atlanta psychiatrist Charles K. Bush, Jr., died October 8 at the age of 69. Dr. Bush was a member of

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ACCREDITED BY THE J. C. A. H.

the staff for Emory University Hospital and deputy director of the State Department of Mental Health. He was a veteran of World War II, a member of the Order of the Eastern Star, Masons and Rotary Club of Atlanta.

Survivors include his widow, Nancy DeGrafft Bush; daughters, Barbara Bush and Nina Bush of Louisville, Ky., sons, Charles K. Bush, III of Due West, S.C. and James M. Bush of Silver Spring, Md.; sister, Miss Catherine Bush of Louisville, Ky.

Charles T. Cowart

Retired LaGrange surgeon, Charles T. Cowart, 58, who served MAG many years at the county, district and state level, died September 30 after a long illness.

Dr. Cowart, a native of Metcalf, was graduated from Emory University School of Medicine in 1941 where he was a member of Alpha Omega Alpha honorary medical fraternity, Phi Delta Theta and Phi Chi medical fraternity.

During World War II, he served in the U.S. Navy Medical Corps. He was in the private practice of medicine in LaGrange from 1949 until his retirement in 1971. Dr. Cowart served as past president of the Troup County Medical Society, past chairman of the Sixth District Medical Society, served on MAG Council and as a delegate. Dr. Cowart also was active in the Georgia Hospital Medical Council as past president, and was past chief of surgery at the LaGrange hospital, where he was a member of the Board of Trustees.

He was a Fellow of the American College of Surgeons, a member of the Southeastern Surgical Congress and Southern Medical Association and active in the LaGrange First Presbyterian Church.

Dr. Cowart's body was donated, according to his wishes, to Emory University School of Medicine.

Survivors include his widow, Eileen Holton Cowart, daughter, Mrs. Judith Langford, both of LaGrange; sons, Charles Glen Cowart of Knoxville, Tenn., Jack Holton Cowart of Brunswick and William T. Cowart of LaGrange; mother, Mrs. Lemuel J. Cowart of Atlanta; two sisters and two brothers.

Homer Harrison Lancaster

Homer H. Lancaster, 75, of Gainesville, a former public health director, died September 16. Dr. Lancaster was born in Hall County and received his medical degree from the Medical College of Georgia in 1928. He had a private practice in Clermont, then Dahlonega and New Holland until 1956, then became Hall County commissioner of health and head of the medical departments of Hall and Banks counties. His health district expanded over the years until it included 13 counties at the time of his retirement in 1972.

Dr. Lancaster was a member of the Alpha Omega pre-medical fraternity, the Lions Club, Elks Club and was a deacon in the Gainesville First Baptist Church. He also served as a director for the First National Bank of Gainesville.

Dr. Lancaster is survived by his wife, Mrs. Lucy Grace Hale Lancaster; daughters, Mrs. Mary Dobbs and Mrs. Martha Byrd of Gainesville; son, James H. Lancaster of Arlington, Va.; three sisters.

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Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

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The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

After three long years of sometimes bitter infighting, the Congress has passed legislation to provide more than $2 billion over a three-year period for medical education assistance.

The long squabble on how many federal strings should be attached and in large part due to the activity of the American Medical Association and other groups those strings have been kept to a minimum.

Commenting on the final provisions of the conference committee action, James H. Sammons, M.D., AMA's Executive Vice President, said, "Many features which we felt were not in the best interests of medical education were dropped—and for this we are very pleased."

Dr. Sammons pointed out that the bill still contains language that will be troublesome, but emphasized that, "The end results of years of work will be a bill that will—overall—help us increase the supply of physicians and the number of physicians in primary care as well as continued support of the National Health Service Corps."

The major battle fought by the AMA, the Administration, and others defeated the prolonged efforts of some to use the so-called Health Manpower bill as a vehicle for federal dictation of curriculum, regional allocations, federal service and licensure of physicians.

As a result of the legislation's passage, medical schools are assured of a continuation of capitation and construction funds, medical students will have increased opportunities for federal scholarships and loan assistance, and the government's National Health Service Corps stands firmly entrenched as an expanding program to channel physicians into shortage areas. In addition, medical schools will be required to produce more "primary care" physicians.

The most controversial feature in the separate bills that had been approved earlier in the House and Senate had been a House provision compelling medical graduates to pay back in money or in shortage area service for the capitation aid their medical schools had received (rather than individual scholarships or loans the students might have taken). This was not contained in the Senate bill nor in the final compromise measure worked out by the House and Senate conferees.

Primary Care Residencies

Only one burdensome requirement of importance remained in the bill. As a condition for capitation aid, medical schools must have in 1978 at least 35 percent of their filled first year positions in direct or affiliated residency training programs in primary care, defined as Family Medicine, General Internal Medicine and General Pediatrics. This percentage rises to 50 percent by 1980.

Rather than requiring certain percentages of medical school graduates to enter shortage area service or join the National Health Service Corps (NHSC), the new medical education bill simply puts up enough PHSC scholarship funds to assure sufficient numbers of young physicians entering the program. Authorized for such scholarships are $75 million for the fiscal year starting this October, $140 million next fiscal year and $200 million for fiscal 1980. Also $51 million over three years was authorized for special scholarships for "students who are of exceptional financial need."

The NHSC also was authorized $174 million for three years for its operations.

For construction of ambulatory, primary care teaching facilities for physicians and dentists, the legislation authorized $120 million for three years.

The capitation grant levels were set at $2,000 per student for the coming fiscal year, $2,050 for fiscal 1979, and $2,100 the next year.

New restrictions were imposed on alien foreign medical graduates including a requirement they return to their country of origin after training. U.S. citizen graduates of foreign medical schools would be given special consideration for acceptance by American medical schools. Medical board and English proficiency tests are specified for immigrating health professionals.

The Health, Education and Welfare Department, under the bill, will prepare sweeping data on health professionals' location, training, etc., "for the purpose of establishing a uniform health professions data reporting system."

The measure provides that new "unaffiliated" residency programs will not be eligible for federal grants and loans, but existing programs are given a "grandfather clause" exemption.

There is no language pertaining to federal relicensure for physicians.

Services for Indians

Congress has sent to the White House legislation to expand medical aid for Indians.

The measure, backed by the AMA, authorizes a three-year program for health professions recruitment and preparatory scholarships for Indians, and for scholarship and extern programs to provide physicians, dentists and other health professionals who would provide health services to Indians.

The bill authorizes construction and renovation of Indian Health Service hospitals, health centers, health stations, and other facilities. It eases medical standards for Indian Health Service facilities and makes the facilities eligible for Medicare and Medicaid reimbursements.

For the first time health service activities for Indians in urban areas would be furnished, including outreach programs, identification of Indians and their health needs, assisting Indians to use community health facilities and the direct delivery of services.

Blood Bank Crisis

Hospital-based blood banks have charged that the American National Red Cross is threatening "a crisis in blood supply which will have an impact on health care delivery."

At issue is the Red Cross decision after 16 years to

cancel its agreement with the American Association of Blood Banks to exchange blood through the AABB's clearinghouse program.

The AABB, which represents most major hospital banks in the country, termed the Red Cross decision—to become effective Oct. 19—a "drastic step" that "will have an adverse effect on the naton's blood supply and will serve to fragment the blood banking system in this country."

Bernice Hemphill, AABB President, told a Washington, D.C. news conference that if the Red Cross carries out its threat, "competition for blood donors between AABB banks and Red Cross centers will increase, and the blood programs of both organizations will be affected by the public confusion that will follow."

The blow-up pits the completely voluntary, no-credit approach to blood collection as embodied by the Red Cross against the individual responsibility of advance credit for giving philosophy of the hospital banks. And the wrangle threatens to jeopardize the careful and deliberate efforts being made by the parent American Blood Commission to bring the competing elements in blood banking together in a voluntary coperative program before the federal government steps in.

The Red Cross was urged by the AABB to reconsider its decision or to agree to national mediation on the issue.

The AABB said it went public with its appeal and protest "not without a great deal of anguish . . . but we no longer have a choice."

Use of SS Number

The AMA has asked Congress to drop a proposed tax provision that would authorize state and local governments to require Social Security numbers to be submitted in administration of any "general public assistance program."

"We are concerned that the term 'general public assistance program' could be defined to include such health programs as local neighborhood health clinics, drug, alcohol, or venereal disease programs, as well as the Medicaid program," said James Sammons, M.D., AMA Executive Vice President.

In a letter to Congress, Dr. Sammons said:

"It is generally recognized that any required submission of Social Security numbers as a condition for participation in the above or other health programs could inhibit public assistance recipients from seeking necessary medical care and also inhibit medical personnel from participating in such programs. Effective delivery of health care to the poor could thus be jeopardized."

He continued: "A confidential relationship between a physician and his patient regarding medical care is necessary, especally with respect to such sensitive medical conditions as venereal disease, drug use, mental illness, and abortion. The individual citizen must be assured that his medical care will be kept in strictest confidence in order to assure that degree of open and candid discussion which is necessary for proper treatment. The current language . . . would infringe upon this right of confidentiality of persons who require public assistance in obtaining medical care."

Dr. Rauscher Resigns

The Director of the National Cancer Institute, Frank J. Rauscher, Ph.D., is resigning because of low pay. Rauscher says he is unable to support five children,

1977 MEETING DATES AND LOCATIONS

MAG Execuive Committee and Council

Date	*Meeting*	*Location*
January 7	Executive Committee	Holiday Inn (airport), Columbus
January 8-9	Council	
February 12	Finance Committee	MAG Headquarters, Atlanta
February 13	Executive Committee	
March 13	Executive Committee	MAG Headquarters, Atlanta
April 21	Executive Committee, Council	Macon Hilton
April 24	Organizational Meeting	
May 27	Executive Committee	Pineisle, Lake Lanier
May 28-29	Council	
June 18-23	Executive Committee	San Francisco, Calif. (During AMA Meeting)
July 10	Executive Committee	MAG Headquarters, Atlanta
August 14	Executive Committee	MAG Headquarters, Atlanta
September 16	Executive Committee	The Cloister, Sea Island
September 17-18	Council	
October 16	Executive Committee	MAG Headquarters, Atlanta
November 20	Executive Committee	Undecided
December 4-7	Executive Committee	Chicago, Illinois (During AMA Meeting)

three of college age, on his present salary of $37,800. He is going to the American Cancer Society to become Senior Vice-President for Research at $75,000.

Dr. Rauscher became head of the Institute in 1972 after Congress gave a major boost to cancer research under the National Cancer Act.

The legislation which expanded NCI, made the director a Presidential appointee and gave him more immediate access to the President and the Congress through the President's Cancer Panel. But the salary of the NCI director, like that of other directors at the National Institutes of Health, is frozen under civil service classification at $37,800.

An attempt this year to increase directors' salaries to $52,000 failed by one vote in the House Commerce Committee.

During Dr. Rauscher's tenure, funding for cancer research increased from $377 million to $815 million this year.

AMA's Foristel Retires

Veteran AMA representative on Capitol Hill, James W. Foristel, retired after 25 years service with AMA's Washington Office. A familiar face to thousands of lawmakers over the years and a close friend to many, Foristel plans to keep his hand in with consultant work in the health field for several organizations including the American Association of Ophthalmology.

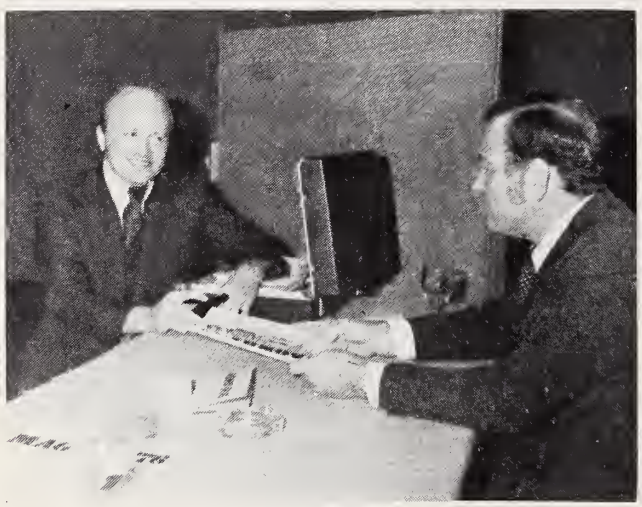
Foristel, a lawyer and World War II veteran, first joined the AMA Washington Office in 1949 and served as its legal and legislative advisor until 1954. He then joined the HEW Department as associate general counsel.

He rejoined the AMA in 1956 and served as Director, Department of Congressional Relations, to 1970 and as Assistant Director until recently.

The AMA House of Delegates, at its recent Annual Meeting in Dallas, Texas, adopted and presented to Foristel a commendation resolution acknowledging his many years of loyal and competent service to the AMA.

The resolution said in part "his perpetual enthusiasm and individual style have made him one of the Association's most effective lobbyists"; and "his unquestioned integrity has brought credit to both the Association and the entire profession of Congressional relations—his expertise has earned him the name 'Mr. Lobbyist' from government and Congressional circles. . . ."

Ave Atque vale!



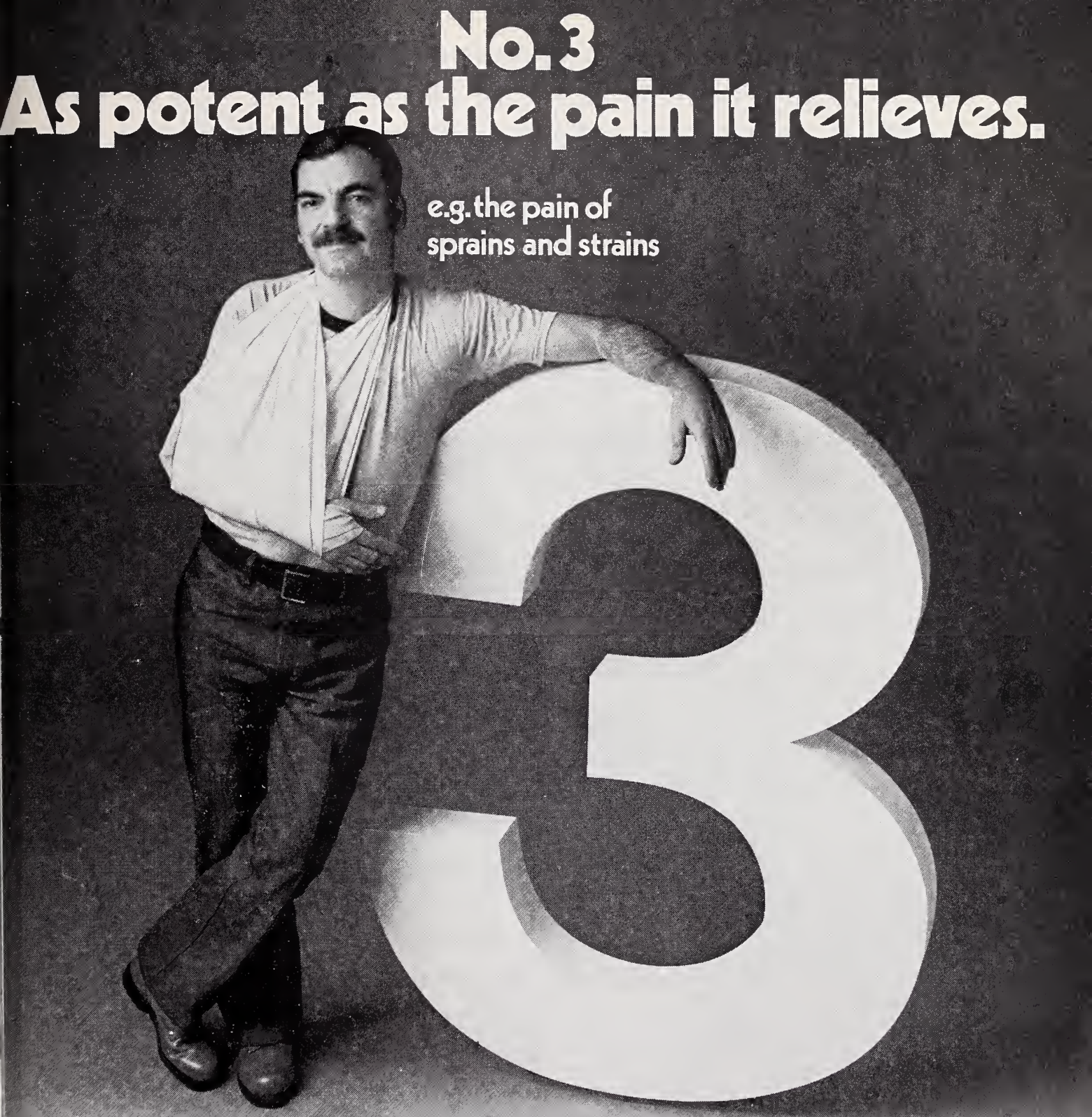


MAGNET CONFERENCE HIGHLIGHTS

One hundred physicians and their medical assistants explored effective practice management concepts during MAGNET '76, held October 23-24 at the Hotel Sonesta in Atlanta. Principal speakers (L) were Duane M. Johnson and Bill McGrath of Practice Productivity Inc. of Atlanta, who led sessions on organizing personnel, effective patient communication, control of time, improving cash flow, and much more.

An afternoon panel (R) examined the "realities" of physician assistants in the doctor's office, concluding that there was high patient acceptance of PAs, who often helped physicians use their office hours more effectively. Leading the panel was (L) Marvyn D. Cohen, M.D. of Columbus, chairman of the MAG Communications Committee who planned the conference. Joining him are Alan B. Sams, a PA from Decatur who is secretary and president-elect of the Georgia Association of Physicians' Assistants; Dave Roberts, M.D. of Columbus; Robert H. Curry, M.D., Atlanta; and, standing, Leon Curry, M.D., of Metter.

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Contact: Chester Lane, (404) 659-0289

AMA CLINICAL CONVENTION
Dec. 4-8, 1976
Philadelphia Convention Center, Philadelphia, Pa.
Contact: AMA Dept. of Scientific Assembly, 535 N. Dearborn St., Chicago, Ill. 60610

AMERICAN ACADEMY OF PSYCHOANALYSIS
Dec. 5-7, 1976
Atlanta
Contact: V. J. Teichner, M.D., 40 Gramercy Park N., New York, N.Y. 10010

SOUTHERN SURGICAL ASSOCIATION
Dec. 6-8, 1976
The Breakers, Palm Beach, Fla.
Contact: W. D. Warren, M.D., Emory Univ. School of Medicine, Atlanta, Ga. 30322

NINTH ANNUAL SHC EDUCATIONAL SEMINAR
Dec. 10-11, 1976
Atlanta
Contact: Southeastern Hospital Conference, P.O. Box 1812, Montgomery, Ala. 36103

CLINICAL PSYCHIATRY
Dec. 9-10, 1976
Augusta, Ga.
Contact: Division of Continuing Education, Medical College of Georgia, Augusta, Ga., (404) 828-3967

TOPICS IN CLINICAL HEMATOLOGY: DISORDERS IN MATURATION
Jan. 10-12, 1977
Ponte Vedra Beach, Florida
Sponsored by the American College of Physicians, University of Florida and American Society of Hematology
Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia, Pa. 19104

SEMINAR REVIEWS INFECTIOUS DISEASES

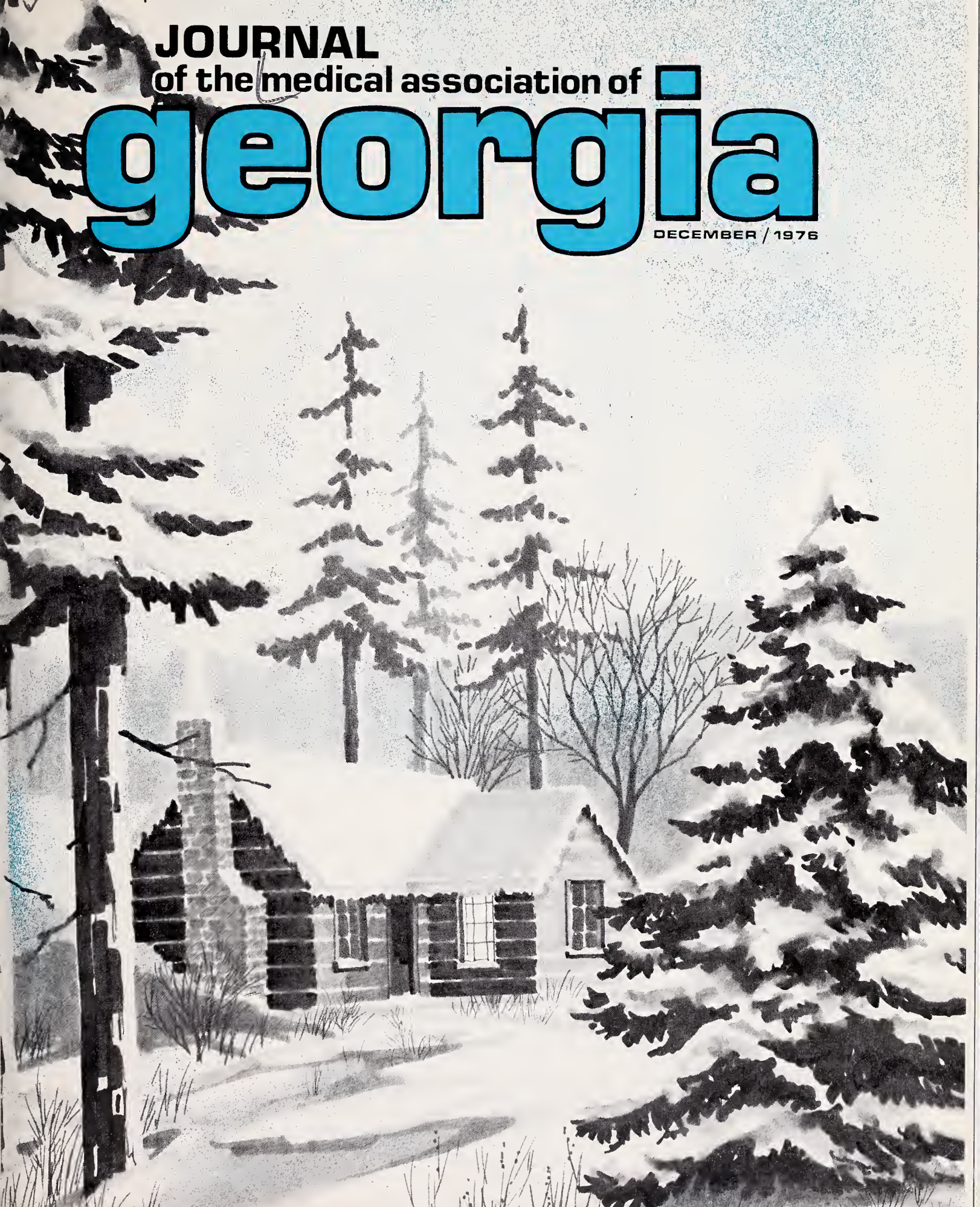
The Georgia Baptist Medical Center will hold its Second Annual Christmas Housestaff Seminar on Tuesday, Dec. 7 from 5:30 p.m. to 9:30 p.m. in the Terrace Level Cafeteria of the Tower Building. The program is titled, "Update 1976—Infectious Diseases, Current Antibiotic and Other Therapy." The program sections include:

1. "Current Antibiotic Therapy in Internal Medicine," by Richard E. DuBois, M.D., chief of medicine at Georgia Baptist;
2. "Antibiotic and Immuno-Therapy in Pediatric Infectious Diseases," by Andre J. Nahmias, M.D., professor of pediatrics at Emory University School of Medicine;
3. "Changing Nature of Surgical Infections with Current Methods of Therapy" by Robert E. Condon, M.D., professor of surgery at the Medical College of Wisconsin;
4. Panel discussion with Drs. Nahmias, DuBois and Condon, moderated by Paul E. Stanton, M.D., director of graduate and continuing education in surgery at Georgia Baptist Hospital;
5. "Update—Swine Flu and Other Forms of Influenza" by Donald Millar of the Center for Disease Control;
6. "Update—Philadelphia Legionnaire's Disease" by David Fraser, M.D. of the Center for Disease Control.
7. Panel discussion with Drs. Millar and Frazer, moderated by Edwin C. Evans, M.D., chief of staff for Georgia Baptist Hospital.

FAMILY PRACTICE PHYSICIANS

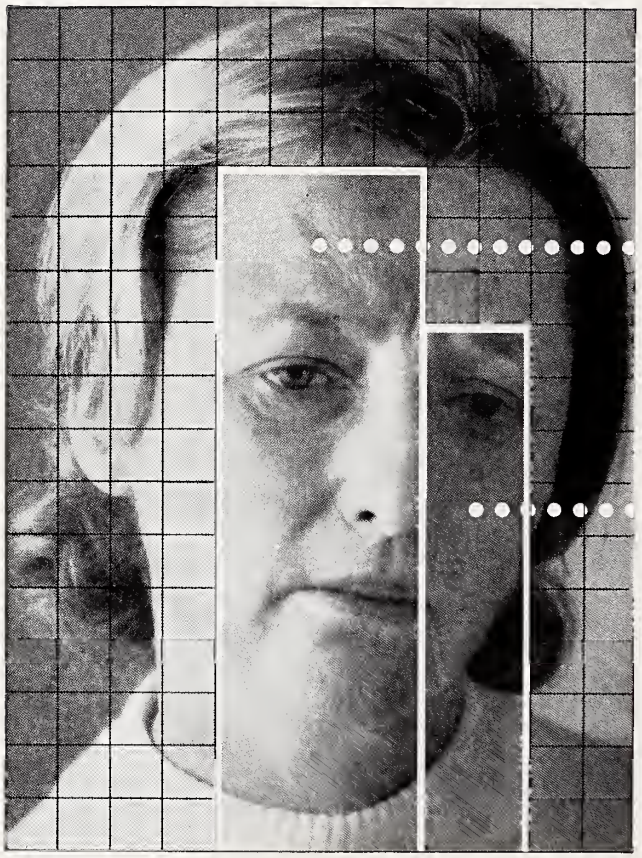
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Brucellosis: A Continuing Problem

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BRUCELLOSIS IS AN ancient disease which was not identified until recent times. Brucella was first isolated by Dr. David Bruce in 1887 from the spleens of British soldiers in Malta (Malta Fever). In 1897 Bang, in Denmark, found the organism caused infectious abortions in cows (Bang's Disease).[12] The disease has been called Undulant Fever due to the characteristic morning-night temperature changes seen in the patients. Fever, headaches, weakness, and lymphadenopathy, the major symptoms of Brucellosis, are associated with a wide variety of infections.[13] Brucellosis often goes undetected and untreated. It is often confused with influenza, infectious mononucleosis, lymphoma, and tuberculosis. It is imperative that a detailed history be taken to facilitate arriving at a proper diagnosis. The incidence of Brucellosis has dropped in recent decades. In the U.S. there were 6,321 cases in 1947, 213 cases in 1970, and less than 200 cases in 1973 and 1974.[3, 12, 13] The highest incidence of the disease occurs in farmers, meat packers, veterinarians, and laboratory workers.

This organism is often overlooked as a human pathogen.

The reservoir for Brucella is animals. In animals the organism tends to lodge in the mammary glands (which causes contaminated milk), genital tract, and pregnant uterus. Pasturization has eliminated most Brucellosis in the U.S., but imported goat cheese does cause cases of the disease.[10, 13] Placental localization of the organism causes abortions in cows. The organism tends to localize in the reticuloendothelial system of man. Brucella suis is the cause of most human infections in the U.S.[2]

The disease can be spread many ways, but the most common cause in the U.S. is via contaminated meat. The incubation period is two to three weeks, but cases have been reported with incubation periods of more than 30 weeks. This makes determination of the source difficult. Other causes are: contaminated milk, cheese, butter, or ice cream; fecal or urinary material of animals; direct contact with infected animals; blood sucking insects or mosquitos; direct human transmission; infectious aerosols; and subculturing in the laboratory. "Nowhere is there a greater occupational hazard than handling highly invasive laboratory cultures."[12] Sulkin, Pike, Phillips, et al., have reported that, "Brucella is one of the most frequent bacterial pathogens involved in laboratory acquired infections."[2, 10] In 1938, 84 of 94 students in class at the University of Michigan contracted the disease in the laboratory.[8] In 1947, 17 cases occurred at Ft. Detrich, Md. in a laboratory working on Brucella.[14]

Records Screened

Our library holdings were screened for all recent cases of human Brucellosis in the literature. The findings in these articles and key review information on Brucellosis are included in this article. The records of our hospital were screened for all patients who had Brucellosis as a proven or suspected diagnosis on their discharge summary. Only patients with a Brucella agglutination titer of greater than 1:100 are included in our findings. Patients' records were screened for occupation, temperature undulations, clinical symptoms, laboratory results, and pertinent history. One recent case is reported to

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illustrate the symptoms, diagnosis, and epidemology of Brucellosis.

Case Report

Clinical History: A 30-year-old white female microbologist was admitted May 21, 1975 with a one week history of fever and diarrhea. She reported loose, watery, greenish stools four to six times daily and several times at night. She tried Lomitol, Kaopectate, and a liquid diet with no relief. She was weak, unable to work, and had lost 25 pounds. Her symptoms included recent lower back pain and LLQ abdominal cramps. She reported headaches and her temperature had varied from 102°-104° F. for the past week. There had been no recent trips out of the U.S. She had recent exposure to Salmonella, Shigella, and fungi in the microbiology laboratory where she works. She works with preserved parasites and dog fecal material. Her history revealed a hospitalization four months earlier for infectious mononucleosis. Palpable enlargement of cervical and axillary lymph nodes was detected on physical examination. Her temperature was 101.3° F. She had an erythematous rash on her legs and abdomen. There were no other positive physical findings. All blood and urine values were within normal limits. Stool exam and culture were negative. Amoeba titer was negative. Blood, urine, and pharyngeal cultures were negative.

Hospital Course: Patient's temperature fluctuated daily from around 98° F. in the morning to 103° F. in the evening during the course of her hospitalization. She began to improve with no treatment. Febrile agglutination tests revealed a Brucella abortus titer of 1:320. Further history revealed the patient had recently subcultured Yersinia enterocoliticia, but a culture for Yersinia was negative. Careful questioning also indicated she was exposed to Brucella cultures in the laboratory. A culture for Brucella on blood agar in 10% CO_2 was positive for Brucella suis.

Due to slow growth of Brucella, the positive findings were not made until after the patient was discharged. Her symptoms rebated without treatment and she was released. She has since received tetracyline therapy as an outpatient due to a continuing Brucella titer and a second positive culture.

Proper Diagnosis Difficult

The results of the study are summarized in Table 1. The above case is typical of our cases and the problems encountered in diagnosing Brucellosis. Because the symptoms are nonspecific, it is difficult to make the proper diagnosis. The diagnosis is also complicated by the fact that the patient had infectious mononucleosis in January, 1975 and a relapse was strongly suspected. Diarrhea, which was her most prominent symptom, is usually not the main problem in Brucellosis. Her fever, weakness, rash and lymphadenopathy fit the typical clinical symptoms (Table 2). The positive Brucella agglutination titer was initially thought to be due to a cross reaction with Yersinia enterocolitica, which she had recently cultured in the laboratory. It was only through careful history taking that it was determined that she had cultured Brucella in the laboratory several months earlier. As with most Brucella patients, she began to improve with bed rest. In every case we studied the period of hospitalization was 14 days or longer. Many of the cases could be directly related to farm animals. One-third (5 of 15) of the cases were due to relapses or re-infections, although all had received tetracycline therapy. Only 47 percent (7 of 15) of the cases had positive cultures, yet all of the cases had an agglutination titer of greater than 1:160.

In no case was there a positive culture and a negative agglutination titer. Biopsies in two of the cases revealed the typical granulomas of Brucellosis. Of significance is that two of the patients had aortic stenosis attributable to Brucellosis. There were no CNS disorders noted which may be due to improved therapy preventing chronic cases from developing.

Discussion

Brucella causes acute, chronic, or nonapparent (asymptomatic) infections with various signs and symptoms (Table 2). The severity varies greatly and the onset is either insidious or sudden. It is in the insidious onset that the nature of the disease is overlooked and treatment is not provided.[12] Brucella is an intracellular parasite. It enters through the skin, conjunctivae, GI tract, or genital system where it is phagocytized by PMNs. The organisms then multiply in the PMNs and are carried through the lymphatics to the lymph nodes, especially cervical and axillary nodes. Upon reaching the lymph nodes, mononuclear cells are invaded and serve as multiplication sites. As cells die and release bursts of virulent organisms, a confrontation develops between the immunological defense system and the pathogens. The degree of chronicity which develops depends on this capacity for multiplication in the phagocytic cells versus the development of cell mediated immunity. Brucella produce a virulence factor in vivo which is not demonstrated in vitro. Marked bacteremias develop as the infected PMNs and mononuclear cells transport the Brucella to the blood, liver, spleen, kidney, and bone marrow. Brucella has a predeliction for the reticuloendothelial

system in man. Focal aggregations develop containing parasitized leukocytes, epitheloid cells, giant foreign body type cells, Langhans type cells, lymphocytes, and plasma cells. There aggregations become the typical small granulomas of Brucellosis found in bone, liver and spleen. The granulomas can be mistaken for sarcoidosis or tuberculosis, but rarely display necrosis or caseation of the tissue.[1, 14]

Brucella also produces an endotoxin. The endotoxin does not cause virulence, but does play a role once an infection is established. Its mechanism of action is unknown, but its most profound effects are on the central nervous system. This leads to headache, lower back and sciatic nerve pain, and depression. Death rarely occurs from Brucellosis. The most common cause of death has been subacute bacterial endocarditis. It has also occasionally caused meningoencephalitis, interstitial nephritis, and orchitis. Death has resulted from suicides caused by depression and psychoneurosis in chronically ill patients.[1, 4, 12]

Both IgG and IgM are associated with the disease, but only IgG is associated with the active state. Chronically ill patients tend to have a high IgG. Patients with high IgM do not tend to have relapses, where those who have a low IgM and a high IgG do tend to have relapses.[2, 7, 9, 15] Cell mediated immunity plays a critical roll in the disease. A marked hypersensitivity develops. Veterinarians who have been previously exposed to the pathogen and accidentally vaccinated themselves have had violent local and systemic hypersensitivity reactions.[4] Resistance is relative and second and third infections

TABLE 2

SIGNS AND SYMPTOMS OF BRUCELLOSIS[1]

Fever	97	Lymphadenopathy	38
Weakness	92	Hepatomegaly	20
Weight loss	90	Constipation	15
Chills	79	Abdominal pain	14
Night sweats	76	Cardiac abnormalities	14
Headache	64	Diarrhea	10.7
Bacteremia	46	CNS disorder	4.9
Nervousness	43	Skin rash	4
Backache	40	Granuloma in liver, spleen, bone marrow, lymph nodes	
Splenomegaly	40		

TABLE 1

BRUCELLOSIS AT EUGENE TALMADGE MEMORIAL HOSPITAL, MEDICAL COLLEGE OF GEORGIA

Year	Occupation	Agglutination Titer	Culture	Weakness, Fever, Headache, Chills/Sweats*	Spleen, Liver Lymph Node Enlargement	History
1959	Farmer	1:1280	Neg.	Yes		Relapse from 1958
1960	Laborer	1:320	B. suis	Yes	Liver, lymph node	Relapse from 1957 and 1958, exposed to goats and cows
1962	Mail carrier	1:320	Neg.	Yes	Liver granuloma	Exposed to deer liver
1963	Slaughter house laborer	1:160	Neg.	Yes		Acute diarrhea, exposed to cows with Bang's Disease
1967	Stock yard laborer	1:1280	Neg.	Yes	Lymph nodes	Relapse, exposed to cows and pigs
1967	Farmer	1:2560	B. suis	Yes		Aortic stenosis, exposed to cows/pigs with abortions
1968	Butcher	1:10,240	B. suis	Yes	Lymph nodes	Aortic stenosis, Brucella myocardia, exposed to cows and pigs meat
1969	Housewife	1:640	Neg.	Yes	Lymph nodes, spleen	Relapse, lives on farm
1969	Saw mill laborer	1:2560	Neg.	Yes	Bone marrow granuloma	Butchered pigs with Bang's Disease
1970	Farmer	1:5120	B. suis	Yes		Exposed to cows with Bang's Disease
1970	Electrician, laborer	1:5120	Neg.	Yes	Lymph nodes	Exposed to farm animals
1971	Factory meat cutter	1:640	Neg.	Yes		Rash, third admission for Brucellosis
1972	Farmer	1:640	B. suis	Yes		Exposed to cows with Bang's Disease
1974	Farmer, asst. veternarian	1:320	B. suis	Yes		
1975	Laboratory technician	1:320	B. suis	Yes	Lymph nodes	Rash, diarrhea cultured Brucella in the Laboratory

* Patient had one or more of the symptoms.

occur (see Table 1). Circulating antibodies often do not prevent a relapse or re-infection.

Clinical Diagnosis

The patient may have any of the symptoms listed in Table 2. Blood and urine values are usually within normal limits. Differential cell count is not normally elevated. The Brucella agglutination test is the quickest and best method of diagnosis, however, a proper standardized antigen must be used. The agglutination test has been positive in almost all proven bacterial cases of Brucellosis. A titer of greater than 1:100 usually indicates an active disease state.[12, 13] There may be a titer of as high as 1:640 with no clinical symptoms.[2] The agglutination test cross reacts with all species of Brucella except Brucella canis.[5] It also can cross react with Yersinia entercolitica, Franciscella tularensis and Vibro chloera. Growth of a culture from skin, lung, feces, liver, lymph nodes, spleen, urine, blood, or bone marrow is a positive indicator, but Brucella is a slow grower (2-30 days) and a negative culture does not rule out a Brucella infection. Blood cultures can be negative when bone marrow cultures are positive.[12] This is especially true of people having relapses. The Brucella skin test, as with the tuberculin skin test, is not diagnostic. It indicates previous exposure to the organism and it may not react for weeks.[1]

Prognosis and Therapy

The disease should not be taken lightly. Treatment should always be administered. Death has occurred in 2 percent of the untreated cases. The disease can last up to five years, but less than 15 percent last over three months.[12] The disease is normally self limiting and bed rest usually brings prompt improvement and a spontaneous recovery. Tetracycline is the drug of choice for a three to four week course of treatment, but more than two courses of treatment are of little value. Both tetracycline and streptomycin are used in severe cases. Relapses occur despite tetracycline treatment and therapy does not appear to affect the frequency of reoccurrence or the development of chronic Brucellosis.[1]

Summary

Our study includes one recent case and 14 previous cases of Brucellosis. Brucella suis infections are common in farmers, meatpackers, and laboratory workers. This organism is often overlooked as a human pathogen. Clinical manifestations are typical of many infections and it is difficult to culture and identify the organism in the laboratory. This infection is potentially dangerous as it causes chronic infection of the reticuloendothelial system and severe CNS disorders. Treatment includes several antimicrobials, with tetracycline being the drug of choice. Brucellosis is a disease for which clinicians should remain alert especially in farm or meat processing communities. Families with dairy cattle should be encouraged to drink pasturized milk. Farm animals should be vaccinated and diseased animals should be destroyed. Meat processors should be cautioned to maintain sanitary conditions and laboratory workers should re-emphasize careful laboratory procedures. When Brucellosis is suspected or there is a positive Brucella titer, an effective regimen of treatment should be initiated. ■

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Leptospirosis Australis— A Case Report

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GEORGIA AND OTHER Southeastern states usually have had more cases of Leptospirosis than other areas of the United States[5] where reports have indicated it may be a relatively rare disease. Leptospira hemagglutination tests in New England indicated that the occurrence of Leptospirosis in 100 jaundiced individuals who had negative HAA tests were all negative for the Leptospiral disease.[1]

This case of Leptospirosis australis probably typifies most cases in that symptoms were nonspecific, but when looked upon as a whole certainly suggest a leptospiral infection. L. australis is a rather uncommon form of leptospiral disease in this country with only 16 reported cases since 1949.[2, 5] In Australia, where L. australis was first cultured, this disease is carried principally by a native Australian rat, Rattus conatus.[7] This organism, however, also has been isolated from other animals. In Southwestern Georgia, animal culture revealed L. ballum cultured in 49 percent and L. hyos in 15 percent of the total number of positive cultures (246), while L. australis accounted for only 3.6 percent of the cultured cases with the host animal being raccoon (Procyon lotor) and opossum (Didelphis marsupialis).[3, 4]

A detailed history and specific serological confirmation are essential in the proper diagnosis and treatment of this infrequently recognized disease.

Known by Veterinarians

In the past, veterinarians have seen the disease in their practices more frequently than physicians and recognize it more readily. Much work in the past concerning reservoir hosts and epidemiology has been done by veterinary physicians.

The patient was a 54-year-old white female who was admitted on August 25, 1975 after having suffered from increasingly severe headaches, pain in the cervical region and nausea for about three days prior to admission. She also had a rather severe cough.

On admission, her temperature was 100.1, P 84, R 16, BP 110/80. Her temperature rose rapidly in the next 24 hours to 103.4 and she was found to have severe cervical rigidity (positive Kernig's). Her pharynx was injected, cervical glands were not enlarged, her heart was rapid but otherwise normal, coarse rales were apparent over both lungs, the abdomen was tender over both the right and left upper quadrants and the liver and spleen were both palpable about 1½ fingerbreadths below the costal margin. Her gait was somewhat unsteady, reflexes were moderately hyperactive, but a physical examination revealed little except for a markedly flushed face.

Her initial CBC showed WBC 5.0 thousand, RBC 4.7 million, Hct 47 percent, Segs 87 percent, 1 percent band, 10 percent lymphocytes and 2 percent monos. Urine showed albumin trace, rare RBC and occasional bacteria. Her chemical profile showed SGOT 42, LDH 242, alkaline phosphorus 82, and total bilirubin 2.

In view of her severe headache and positive Kernig's, a spinal puncture was done and showed no bacteria, glucose 57 mg percent and protein 73 mg percent. Bacteria culture reports revealed no growth. India ink stain showed no organisms present. Total cell count 10. Other tests done included mono test, urine for cytomegalovirus, febrile agglutinins, RA and ANA tests, stool cultures and australian antigen, all of which were negative. Chest x-ray was negative, GB and GI were normal and EKG was normal. Histo and TB skin test negative and bone marrow culture and cytology were negative.

The patient was very confused during most of her first three days, but did state that she had been fishing in a small stream which passed through a swampy area. She also said that during this time she waded in mud for some time almost to her knees. She denied having any pets around the house, nor did her neighbors and she had not been around any cattle.

On the third day of hospitalization, the patient developed an urticarial eruption covering both lower extremities and this disappeared completely in 24 hours. This factor, coupled with her symptoms and other negative findings, suggested the possibility of Fort Bragg's disease, which is due to a type of leptospirosis.

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Her treatment consisted of tetracycline, and her fever and other symptoms subsided rapidly. She was discharged on August 29, 1975 with a tentative diagnosis of Fort Bragg's disease. She was told that if this diagnosis were confirmed by the Center for Disease Control (CDC) she might expect a recurrence of her symptoms within the next two weeks.

Indeed, she was seen on September 13, 1975 still complaining of severe headache. This was prior to the return of L. australis results from the state laboratory. Repeat lumbar puncture and brain scan were within normal limits with CSF protein recorded at 46 mg percent, which was reduced from earlier recording during this acute illness.

The reports of frozen specimen of serum from the CDC (complement fixation) were strongly positive for Leptospirosis titers (1:6400) sub type australis rather than the Fort Bragg type. This latter was performed on a specimen obtained two weeks after the onset of her illness, as the initial specimen obtained during the acute phases unfortunately was broken in transit.

As in other cases of Leptospirosis, the diagnosis can be difficult to make unless a good history is obtained to document possible exposure. However, even without this history, this disease still must be considered strongly when a patient presents with rather continuous fever, headache, stiffness, and myalgia. Frequently, it is diagnosed as aseptic meningitis, hepatitis, FUO or influenza. This disease occurs most frequently in males, and those with occupations such as farmer, laborer, student, slaughterhouse worker. It is most prevalent between July and October, and those affected usually have been exposed to animals or stagnant water.

Multiple organ involvement can occur with the disease, but it usually attacks the central nervous system (68 percent), kidney (51 percent), liver (48 percent) and lungs (27 percent). Backache also is a frequent complaint in approximately 82 percent of the cases. Laboratory data to support diagnosis is elevated white blood count, jaundice, hematuria, pyuria, elevated spinal fluid protein, elevated liver function test, and other less frequent findings.

Therapy and Mortality

Direct darkfield examination of blood and urine sometimes is helpful in making the diagnosis and yet frequently results in failure. Antibodies usually appear from the sixth to the twelfth day of illness. There are four serologic tests available, but the most dependable diagnostic test probably is a complement fixation test. Since diagnosis is rather difficult and antibiotics are of benefit only when given early, it would appear that in very suspicious cases it might be advisable to administer penicillin G or tetracycline to the non-sensitive individual.

Treatment of Leptospirosis apparently has been most beneficial when either penicillin G or tetracycline is used and it has been found to be most effective when given in the first two to four days of the onset of illness. It is agreed that treatment after the fifth day from onset has little beneficial effect. Due to the usual delay in diagnosis, this leaves only bedrest and supportive treatment as the chief measures available.

In case of azotemia and jaundice, close attention to electrolytes and fluid retention apparently is of greatest importance.

The chief causes of death in cases of Leptospirosis concern hepatic and renal involvement, and are more common in the very young and elderly patients. The severely jaundiced type, commonly known as Weil's Syndrome, frequently is accompanied by hemolytic complications as well as aseptic meningitis. Other complications are myocarditis, iridocyclitis, optic neuritis and other nervous system manifestations including encephalitis, myelitis, and peripheral neuritis. These complications occur most frequently during the secondary phase of the illness. It is not definitely known whether these complications are due to this infection or due to immunologic responses to the infection.

This patient presented a majority of those findings (history, physical and lab) of Leptospirosis. We feel that there are many cases seen that are not diagnosed because they do not have all the typical data. As a result, these are called "viral disease" or influenza and the reason for these diseases is never found.

In order to make the diagnosis, serologic evidence must be sought in cases that do not follow the usual short febrile illness, and this may lead to surprising results. ■

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Journey to Jefferson

MRS. WILLIAM C. COLLINS, *Atlanta**

ONE MORNING IN June three of us from the Auxiliary to the Medical Association of Atlanta, Tina James, president of our Auxiliary, Ellen Goldman, our official photographer, and I set out for the little town of Jefferson, Georgia. Jefferson is northeast of Atlanta and has as its "claim to fame" the Crawford W. Long Museum. We had in tow a beautiful oil painting of Crawford W. Long as a young man.

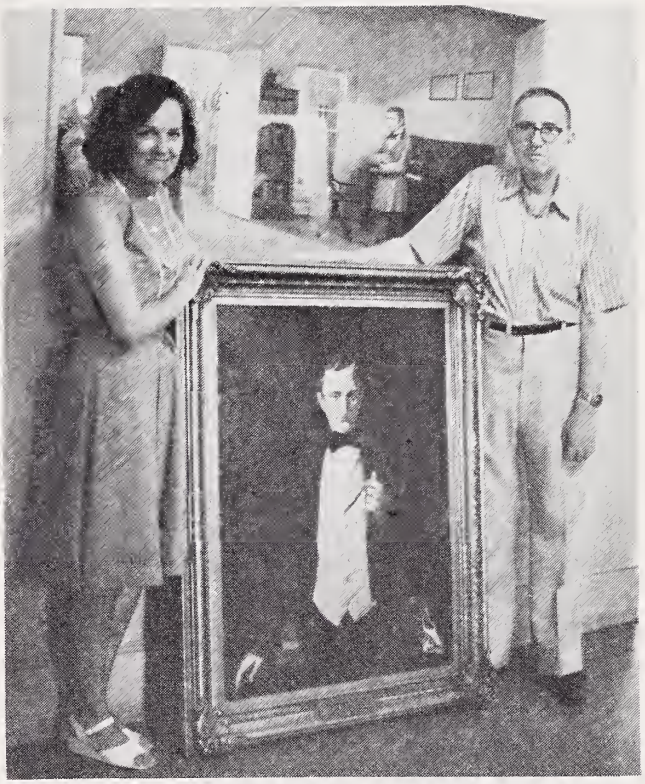
How we procured the painting is a story in itself. The May meeting of our Auxiliary was held in the new home of the Atlanta Historical Society, and Dr. William Pressley, director of the Historical Society, was our speaker. Upon hearing announcement made of the re-opening of the Crawford W. Long museum, Dr. Pressley promptly offered us the loan of an oil painting of Dr. Long for display in the museum in Jefferson. It seems that the Trust Company of Georgia had commissioned Lewis Gregg to paint a collection of famous Georgians to hang in the lobby of the bank's main office. In the late 1960's the Trust Company donated this group of paintings to the Atlanta Historical Society. Dr. Pressley decided that Jefferson was the fitting home for the Long portrait.

Our trip started on a humorous note as we jauntily drove to the Historical Society in a small sports car to pick up the painting. The mammoth proportions of the portrait brought us to the realization that we were driving the wrong vehicle. Twist and turn as we would, we simply could not fit Dr. Long into the car! Later we returned to the Historical Society driving a Suburban truck!

Site of Long's Office

As we drove through Jefferson, we got the impression of a small, pleasant, typically Southern town. The museum was housed in a sturdily-built and obviously old two-story brick building. Outside is a stone plaque announcing that this is the site, not the original building, of Dr. Crawford W. Long's practice of medicine in Jefferson.

We were met at the door by Mr. and Mrs. Frary Elrod, who have been the driving forces in the development and management of the Crawford W. Long Museum. Mr. Elrod, retired Jackson County School Superintendent, serves as curator of the museum.



MAA Auxiliary President Mrs. Scott James presents a portrait of Crawford W. Long to museum curator Frary Elrod. Providing a backdrop is the detailed diorama depicting the scene when Dr. Long first used ether as an anesthetic in surgery.

It was soon obvious to us that the Elrods are totally devoted to this museum and probably are the greatest living authorities on Crawford W. Long. Our tour of the museum directed by the Elrods helped bring into focus for us Dr. Long's life and accomplishments.

Entering the building, our attention was caught by the striking seal of the museum etched in lucite and designed by Sheila Kelly Caldwell of Athens.

The focal point of the first floor is a diorama of Dr. Long's historic first operation using ether. The beautifully-crafted diorama was hand-carved by a company in Florida at a cost of $4,000. Mr. Elrod

* Immediate past president of the Auxiliary to the Medical Association of Atlanta. Mrs. Collins' address is 6000 Winterthur Dr., N.W., Atlanta, Georgia 30328.

chuckled as he told us of taking a sample of Georgia clay to the artists, because they wouldn't get the dirt in the diorama red enough!

The first floor of the museum is devoted to telling the life story of Dr. Long through his personal possessions such as letters, photographs, busts, books, ledgers and medical records. Of special interest to us were Dr. Long's cradle, a letter from his wife chastising him for irregular church attendance, and his degree of Medicine from the University of Pennsylvania.

Conquest of Pain

On the second floor is the chronological story of the conquest of pain from the primitive medicine man's rattle to the sophisticated anesthetic equipment of today.

After we made a quick tour of all the exhibits, we came back downstairs to try to absorb something of the life of this giant of medicine. We learned that he was born in Danielsville, Georgia November 1, 1815, the son of a planter, merchant and state senator. Crawford Williamson Long attended the University of Georgia, then called Franklin College, and graduated with a master's degree in 1835. Interestingly enough, his college roommate was Alexander H. Stephens, who later became Vice President of the Confederacy. As Mr. Elrod pointed out, Crawford W. Long and Alexander Stephens are still rooming together, as Georgians in the National Hall of Fame in Washington, D.C.

After college, Long came to Jefferson and "studied" medicine for a year with a Dr. Grant. He then continued his medical education at Transylvania College in Lexington, Ky. From there he went to the medical school of the University of Pennsylvania and interned in New York hospitals.

Dr. Long returned to Jefferson in 1841, and bought the office of Dr. Grant with whom he had studied some years earlier. Jefferson at this time was a town of less than 100 people!

Experiments With Ether

As a 25 year old bachelor, Crawford Long probably was a welcome addition to the social life of Jackson County. A fad among the young people of the 1840's was the inhaling of nitrous oxide or "laughing gas" at their social gatherings. Some of the young men of the community asked Dr. Long to provide some of this laughing gas for an upcoming party. Dr. Long told them that he couldn't make nitrous oxide, but he could supply them with sulphuric ether which would have the same effect.

As "ether frolics" became even more popular, Dr. Long observed the effects of ether on those partygoers who indulged. He noticed that those who only sniffed a little ether simply acted silly, while those sniffing larger doses staggered and fell but seemed to feel no pain. Dr. Long even experimented with the effects of ether on himself. One story circulating tells of the time Dr. Long sniffed ether at a party and went around kissing every girl there. He later confessed to a friend that the ether didn't make him that demonstrative, but it simply provided a good excuse for his behavior!

On March 30, 1842, Crawford Long put this gas ether, used before only as a plaything, to scientific purposes. He surgically removed a cyst from the neck of James Venable using ether for the first time as an anesthetic. Venable declared he felt no pain during the operation.

Long performed other operations in 1842 and 1843 using ether, but he did not publish his results until 1849 in the *Southern Medical and Surgical Journal*. He explained that he had waited that long to disclose his findings because he wanted to gather a sufficient number of cases to make a valid claim as to the benefits of ether in painless surgery.

Ether Controversy

During these years others were experimenting with ether, also. A Dr. William T. G. Morton, a Boston dentist, used ether in 1846 on a patient before extracting a tooth. Ether had been suggested to him as an effective pain-killer by Charles T. Jackson, a Boston chemist; consequently, Morton and Jackson, along with Long, all claimed credit for the discovery of ether as anesthesia. This led to the "Great Ether Controversy."

Speculation is that Jackson, who was somewhat of an adventurer may have come to Georgia during the Dahlonega Gold Rush and heard of Long's use of ether. The stagecoach route between Augusta and Dahlonega ran right through Jefferson!

Dr. Long's records, photocopies of which are in the Jefferson museum, establish without a doubt Dr. Long's priority in use of ether as anesthesia four years before either Morton or Jackson.

On August 11, 1842, Crawford Long married May Caroline Swain, niece of the Governor of North Carolina. After nine years of medical practice in Jefferson, Dr. Long moved his family to the bustling town of Atlanta. His family eventually grew to 12 children, and we wonder if Dr. Long moved to a larger area to give his children more educational benefits. At any rate, Atlanta proved to be too large for Dr. Long, so he again moved his family, after a year in the "city," this time to Athens where he

lived out his days, accumulating 40 years in the practice of medicine.

During the Civil War, Dr. Long was in charge of the Confederate hospital in Athens. A fascinating document in the museum is his pardon and restoration to citizenship issued by the United States government after the Civil War.

A Museum Is Built

As we completed our tour of the museum, we became curious as to how it all came about. Wasn't this a large undertaking for a town the size of Jefferson? Mr. Elrod told a familiar story of how a few concerned citizens got together and decided that Crawford W. Long should be honored in the town where he made medical history. In 1951, the townspeople raised $2,500 to buy the property where the museum is housed, and the site of the original office.

Governor Herman Talmadge made possible a grant of $35,000 to the Georgia Historical Commission for equipping the museum. Donations from the Medical Association of Georgia contribute to the maintenance of the museum.

On Sept. 25, 1957, the Crawford W. Long Museum was dedicated. The first visitor to sign the guest book was a Dr. Crawford W. Long, a distant relative of Dr. Long, the pioneer of medicine. He noted with interest that one of his classmates at the Tulane Medical School was a man by the name of James Venable, the same name as the first ether patient!

In 1933, Mrs. Charles B. Almond of Winder suggested that the doctors of Barrow County be honored on March 30, the anniversary of Dr. Long's first use of ether in surgery. Little did she know that in 1958, the Congress of the United States would commemorate Doctors' Day on a national basis. Now, each year on March 30 we honor our doctors as well as pay tribute to Dr. Crawford W. Long, "the discoverer of anesthesia, distinguished in his native State of Georgia and the nation, by rendering an immortal service to mankind."[1] ■

REFERENCE

1. *Doctors' Day,* Woman's Auxiliary to the Southern Medical Association, 1957.

Opportunities for Continuing Medical Education

TOPICS IN CLINICAL HEMATOLOGY: DISORDERS IN MATURATION
Jan. 10-12, 1977
Ponte Vedra Beach, Florida
Sponsored by the American College of Physicians, University of Florida and American Society of Hematology
Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia, Pa. 19104

VASCULAR DISEASES

Jan. 25, 1977
Veterans Administration Center, Dublin
Sponsored by the Laurens County Medical Society, VA Center and Medical College of Georgia
Contact: Grady E. Longino, M.D., Secy. of the Laurens County Med. Society, VA Center, Dublin, Ga. 31021

RHEUMATIC PROBLEMS IN THE OLDER PATIENT

Jan. 28, 1977
Spartanburg General Hospital, S.C.
Approved for 7 hours AMA category I credit, and 7 hours AAFP required credit.
Contact: David K. Stokes, Jr., M.D., Spartanburg Gen. Hosp., 101 East Wood St., Spartanburg, S.C. 29303.

OPHTHALMOLOGY AND PULMONARY DISEASES

Feb. 1, 1977
Ft. Oglethorpe
Sponsored by the Hutcheson Memorial Tri-County Hospital, and Medical College of Georgia
Contact: Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Ft. Oglethorpe, Ga. 30742

THE IMPAIRED PHYSICIAN: ANSWERING THE CHALLENGE

Feb. 4-6, 1977
Hyatt Regency Hotel, Atlanta
Sponsored by the AMA and the MAG
Contact: Dept. of Mental Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610

40th ANNUAL NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

March 28-31, 1977
The Fairmont, New Orleans, La.
Registration: $125, military, $62.50, complimentary to students, residents, interns and fellows
Contact: The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Ave., New Orleans, La. 70112; (504) 525-9930.

An outline of recommendations for the use of blood is made, with a caution that professional judgment is needed in all situations.

Use of Blood and Blood Products

A. B. GLASSMAN, M.D.,* P. J. LARISON, M.T. (ASCP) B.B. *and*
J. E. SHIPPEY, M.D., *Augusta*†

PROPER USE OF blood and blood products remains a vital concern to all physicians. As the art and science of immunohematology and hemotherapy has advanced, the use of the components of a unit of whole blood has become mandatory. Since blood and blood products are a prescription item, the following information has been developed for the use of the more common blood and blood products available from the Blood Bank of the Clinical Laboratories of the Eugene Talmadge Memorial Hospital at the Medical College of Georgia.

Adequate instruction for the use of the described products by physicians is required by Federal Drug Administration guidelines. The clinical use of blood involves professional judgment and decisions which cannot be anticipated in any sort of prepared statement or document. For these reasons, this is an outline of recommendations for the use of blood and blood products. It should not be considered or interpreted as an expressed or implied warranty of the safety, fitness or proper use of the described products.

Storage and Administration

The following precautions or limitations related to the storage and/or administration of blood products should be kept in mind:

1. Storage within a 2°C range between 1 to 6°C in a temperature controlled and monitored refrigerator must be maintained up to the time of transfusion.

2. Blood must be inspected immediately before use and rejected if there is an abnormal color or appearance. Blood released to the user for transfusion cannot be accepted back in the Blood Bank for reissue, because the blood would not have been monitored in a temperature controlled refrigerator.

3. If a technical or clerical error exists such as in the numbers, identification, labeling or attached materials, do not administer the blood or blood products until the problem has been completely resolved.

4. Medications should not be added directly to the blood unit.

5. Warming may be hazardous and should be avoided except under controlled and specific conditions (e.g. massive transfusions given through a temperature controlled water bath coil).

6. Immediately before use, resuspend blood components by gentle inversion of the unit.

7. Before administration, the blood or component container and the intended compatible recipient should be carefully identified by two persons. They should verify the patient's name, hospital number, ABO group and Rh type recorded on blood labels and transfusion form, and certify them to be identical and correct.

8. Recipients should be carefully observed during the initial phase of a transfusion. Most major hemolytic transfusion reactions, such as those caused by clerical error (e.g. ABO incompatibility), occur within the first 15-50 cc of transfusion.

Blood and blood products, herein discussed, are administered intravenously through a transfusion set with a sterile pyrogen free filter. The quantity administered, frequency, and duration of therapy is determined by the clinical status of the patient and collaborative laboratory tests. Replacement should be sufficient to produce the desired clinical results. The rate of administration usually varies from 5-10 cc per minute, but may be slower or faster when the clinical situation indicates.

11. No warranty can be implied as to the safety of any unit of blood or blood products related to possible transmission of hepatitis, even though radioimmunoassay (RIA) or reverse passive hemagglutination (RPHA) tests for hepatitis B surface antigen (HB_sAg) are performed.

Cautions for Use

General cautions for blood and blood products include:

1. Hemotherapy requires the judgment of a physi-

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† From the Medical College of Georgia, Augusta, Ga. 30902. Supported in part by the Medical Research Foundation of Georgia.

cian to balance potential hazards against therapeutic benefits.

2. Transfusion of whole blood or red blood cells would be preceded by ABO and Rh typing, antibody screening and adequate compatibility testing between donor and recipient. Complete cross matching requires approximately 45 to 60 minutes. In critical emergencies, the attending physician must justify in writing the omission of the compatibility tests. The laboratory will subsequently perform these compatibility tests without further request from the physician.

3. The principal hazards and adverse reactions to blood and blood products include:

a. Transmission of infectious diseases such as hepatitis, malaria, syphilis, cytomegaloinclusion virus, toxoplasmosis and others.

b. Hemolytic transfusion reactions.

c. Febrile reactions.

d. Allergic reactions.

e. Circulatory overload.

f. Air embolism.

g. Citrate toxicity.

Blood and Blood Components

I. *Whole Blood, (Human)*

(a) Description of the product:

1. Whole blood units contain 450 cc's (± 10 percent) of whole blood preserved and anticoagulated in either Citrate Phosphate Dextrose (CPD) solution, Acid Citrate Dextrose Solution (ACD) or, rarely, Heparin.
2. CPD is the most commonly used preservative because the solution is less acid than ACD, exerts less alteration in the mean corpuscular hemoglobin concentration, has a higher 2, 3 diphosphoglycerate (2, 3 DPG) level in the red cells, and maintains a more physiologic pH.

Smaller volumes may be obtained by either collecting blood into a multiple bag unit and transferring aliquots into satellite bags (closed system—21 day expiration) or entering a whole unit with a transfer set and transferring aliquots into sterile labeled containers (open system—24 hr. expiration date).

(b) Indications for use:

1. Whole blood can be used in situations when both red blood cells and plasma are needed as in acute hemorrhage (loss of more than one liter of blood in an adult) or hypovolemic shock. Red cells supply the oxygen carrying capacity and the plasma supplies volume, proteins, oncotic pressure and some clotting factors. Whole blood is an inefficient use of blood components resulting in the potential waste of fresh plasma, AHG cryoprecipitate and platelets. For these reasons, approximately 80 percent of transfusions could take place as human red blood cells.
2. Heparinized whole blood was primarily used for priming, pump-oxygenators necessary for maintaining extracorporeal circulation during cardiac surgery. CPD whole blood (Human) less than five days old, modified by the addition of heparin and calcium chloride prior to use is now more generally used for priming pump oxygenators.

(c) Expiration

1. CPD or ACD
   Closed system—21 days
   Open system—24 hours from the time of entering the unit
2. Heparinized whole blood (Human) expires in 48 hours.

II. *Fresh Whole Blood, (Human)*

(a) Description of the product:
Same as whole blood except the blood is less than 24 hours old and contains some platelet activity, and Factors V and VIII.

(b) Indications for use:
The requirement for fresh blood is usually minimal and limited. This must be reviewed in our institution by the patient's physician and the blood bank medical director or his designee. It must be justified by the clinical and laboratory findings manifested by the patient in relation to those factors supplied in fresh blood versus specific components.

(c) Cautions:
Because fresh blood is usually ordered in emergency situations, time does not permit radioimmunoassay HB_sAg testing. A release must be signed when blood or blood products are issued without proper hepatitis testing.

(d) Expiration:
Fresh blood greater than six hours of age has greatly diminished platelet function. Factors V and VIII are present in approximately 50 percent of original activity for up to seven days of storage. 2, 3

DPG levels remain at close to physiologic levels for at least the first three to five days of shelf storage when the unit is collected in CPD anticoagulant.

III. *Red Blood Cells, (Human)*

(a) Description of the product:
The cells are prepared by aseptic removal of most of the plasma from either sedimented or centrifuged whole blood. Plasma may be removed at any time during the 21 day dating period if prepared by undisturbed sedimentation. Preparation by centrifugation should be done within six days of collection. Both methods leave a unit of packed human red blood cells with a hematocrit of approximately 70 percent to 80 percent.

(b) Indications for use:
1. Treatment of hypoxic or anemic conditions not associated with the need for volume, oncotic pressure or specific clotting factors.
2. Red blood cells decrease the risk of circulatory overload, unnecessary infusion of sodium, potassium, ammonia, citrate and ABO isoagglutinins.
3. Many chronic anemias such as those associated with chronic inflammation, malignancy or hyporegenerative bone marrows.
4. Red blood cell transfusions make possible the use of one unit of blood for several patients when the initial unit was drawn in multiple packs. Various components may be prepared such as platelet concentrates, fresh frozen plasma, cryoprecipitates, albumin, etc. for patients who need specific components.

(c) Contraindication
Should not be used if a specific product would correct a patient's anemia (e.g. B_{12}, iron, folic acid) within a reasonable time.

(d) Caution
When viscosity presents a problem in transfusion of the red blood cells, approximately 50 cc of intravenous sterile isotonic sodium chloride may be added to the cells through a Y infusion set immediately before the transfusion.

IV. *Red Blood Cells, (Human), Leukocyte Poor*

(a) Description of the product:
May be prepared from whole blood less than six days old by either inverted centrifugation, saline washed red cells, nylon filtration, dextran sedimentation, or reconstituted frozen red blood cells.
1. Using the inverted centrifugation method the leukocyte poor red blood cells are prepared from an inverted centrifuged unit of whole blood. The centrifuged cells are aspirated from the bottom of the inverted unit, leaving most of the buffy coat and supernatant plasma. By this method the leukocytes are reduced 60 to 70 percent with loss of 20 to 25 percent red blood cells.
2. Using the automated saline batch washed method, the red blood cells are washed and agitated several times with 1000 to 2000 cc's of 0.9 percent sterile intravenous sodium chloride solution followed by decanting the supernatant. This method has a white cell residual of approximately 7.2 percent (90 percent or greater white cell removal) with recovery of 85 percent of the red blood cells.
3. The extensive washing or agglomeration procedures, associated with deglycerolization of the frozen red blood cells, removes plasma and most of the microaggregates of cells and cell debris. The recovery of red blood cells and white cell residual will depend on the method used in deglycerolization.

(b) Indications for use:
1. Indicated for patients who have developed leukocyte antibodies resulting from repeated transfusions or pregnancies, and who have experienced a reaction (chills and fever) to the leukocytes in unmodified whole blood or red blood cells.
2. Indicated for potential organ transplant recipients.

(c) Expiration:
24 hours once the unit is prepared as leukocyte poor red blood cells.

V. *Platelet Concentrates:*

(a) Description of the product:
Platelet preparations are processed either from (1) an individual donation of whole blood drawn in a triple pack system yielding one pack, (2) a double plasmapheresis procedure using a series of bags connected by integral tubing or (3)

prepared by intermittent flow centrifugation which can yield the equivalent of six to 10 units of platelet concentrates from a single plateletpheresis. In general, the product is obtained by withdrawing blood from a donor, the plasma and red blood cells are then separated by light centrifugation. The separated cells are returned to the donor and the plasma is recentrifuged to concentrate the platelets. A unit of platelet concentrate prepared from a single unit of blood will raise the platelet count approximately 10,000 platelets/mm^3 in an average sized adult at a time approximately two to four hours after infusion. The platelet increment expected from a unit of platelets prepared by intermittent flow centrifugation can be expected to yield a value approximately six to eight times that of a single unit of platelet concentrate. The patient should be followed by clinical bleeding response and platelet counts at zero time, four hours and 24 hours post infusion.

(b) Indications for use:

1. The prime clinical use of platelet infusion is in the treatment of the thrombocytopenic patients. If the platelet count is below 10,000, platelets per mm^3 of blood, the risk of hemorrhage is considered great.
2. Prophylactic platelet transfusions may be required for patients with temporary depletion of platelets due to acute leukemia, chemotherapy, after cardiopulmonary bypass and in instance of major surgery and/or massive transfusions.

Cautions:

1. The clinical effect of platelet transfusions is transient. The transfused half-life of platelets is approximately three to five days. These increments may be further reduced in patients with fever, sepsis, active bleeding, splenomegaly, or platelet antibodies.
2. Patients with I.T.P. or disseminated intravascular coagulation may not benefit from platelet infusions.

(c) Administration

1. Platelets are administered through a special transfusion set. Do not use the usual blood administration sets for platelet infusions. The special platelet administration set contains an 80 micron mesh filter with sterile needle and may include a 60 cc sterile syringe. The filter removes aggregated platelets or fibrin particles which may otherwise cause emboli.
2. Concentrates are pooled aseptically just prior to administration. Each concentrate should be gently mixed before being pooled.

(d) Expiration:

Platelets are labile. Platelet preparations should ideally be prepared and transfused as soon as possible after collection. They can be stored and transfused for up to 72 hours after preparation.

VI. *Single Donor Plasma, (Human) Fresh Frozen*

(a) Description of the product:

This is the liquid component prepared from whole blood by centrifugation and aseptic removal within four hours of collection from the donor, and frozen within six hours at a temperature of –30°C.

(b) Indications for use:

1. Clotting deficiency when concentrates are not available or clotting factor has not been fully diagnosed.
2. Pre and postoperative treatment of patients with appropriate plasma coagulation factor deficiencies.

(c) *Cautions:*

1. Because of fibrin precipitation occurring in thawed plasma, it must be administered through a sterile pyrogen-free filter set.
2. The incidence of hepatitis is in proportion of the amount transfused, e.g. the hepatitis risk for each unit is additive.

(d) Expiration:

Plasma frozen at –30°C expires one year from the freezing date. Once thawed, the plasma must be transfused within two hours. It cannot be refrozen.

VII. *Red Blood Cells (Human) Frozen:*

(a) Description of the product:

Blood is collected according to standards equivalent to those used in the preparation of whole blood. Within six days of collection, the red blood cells are transferred aseptically into a sterile disposable special plastic blood freezing unit and glycerated using 8.6 molar glycerol solution. The glycerated blood is then stored continuously at –85°C. (High glycerol, slow freezing technique.)

VIII. *Red Blood Cells (Human) Deglycerolized:*

(a) Description of the product:

1. Deglycerolized red blood cells are prepared by the addition to the thawed cells of 50 percent dextrose and five percent fructose. The sugar washed cells are resuspended in 250 cc of 0.9 percent sodium chloride solution, centrifuged and the red blood cells packed by expressing the saline supernatant into an attached container. This method is that described by Tullis and Huggins and is commonly known as the agglomeration method of deglycerolization.
2. Frozen red blood cells may also be deglycerolized by washing with decreasing gradients of buffered sodium chloride solutions in a continuous flow centrifuge. The final product being suspended in 0.8 percent sodium chloride with 0.2 percent dextrose (Meryman Technique).

(b) Indications for use:

1. This blood component is to be preferred for pre and post transplant patients to prevent human leukocyte antigen (HLA) sensitization.
2. Red blood cells (Human) deglycerolized are preferable for patients who have been previously sensitized to leukocytes and platelets by previous transfusions. This is especially true in patients who will be undergoing long-term transfusion therapy such as sickle cell anemia and thalassemia.
3. For autotransfusions primarily used for patients with multiple antibodies whose own red blood cells have been frozen for their use as needed.
4. For rare blood types (e.g. rare donor unit storage).
5. Frozen deglycerolized red blood cells result in a statistically significant reduction in the incidence of hepatitis and are virtually free of plasma proteins, white cells and platelets. Use of this product will result in reducing the incidence of immunization to these antigens and transfusion reactions.

(c) *Caution:*

Frozen red blood cells must be processed completely as with any regular unit of blood and must be crossmatched prior to transfusion.

(d) Expiration:

Deglycerolized red blood cells expire in 24 hours after they have been thawed and washed. ■

REFERENCES

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3. *Manual of Blood Component Preparation,* Chicago, Ill., American Association of Blood Banks, 1975.
4. Meryman, H. T. and Hornblower, M.: A method for freezing and washing red blood cells using a high glycerol concentration; *Trans.* 12:145, 1972.
5. Mollison, P. L.: *Blood Transfusion in Clinical Medicine,* Fifth Edition, Oxford, Blackwell Scientific Publications, 1972.
6. *Red Cell Freezing,* Chicago, Illinois: American Association of Blood Banks, 1973.

HEART ASSOCIATION OFFERS ADVANCED LIFE SUPPORT INSTRUCTOR COURSE

Physicians who want to become certified as instructors in Advanced Cardiac Life Support (ACLS) are registering for a course to be presented by the Georgia Heart Association Jan. 28-30 at Howard Johnson's Airport Motel, 1377 Virginia Ave., East Point.

National faculty for the course will be Judith Donegon, M.D., assistant professor of anesthesiology at the Medical College of Wisconsin in Milwaukee. She is chairman of the American Medcial Association's CPR liaison committee and the American Society of Anesthesiologists' sub-committee on ACLS workshop.

This standard course was developed by the American Heart Association as directed by the National Academy of Sciences-National Research Council. It is designed for cardiologists, emergency room physicians, anesthesiologists and other physicians actively engaged in the area of advanced cardiac life support.

A prerequisite for the course is the prior satisfactory completion of a Basic Cardiac Life Support course, preferably at the level of instructor or above.

Robert F. Finegan, M.D., anesthesiologist and chief of staff at South Fulton Hospital in East Point, is director of the course. He is a member of American Heart Association's affiliate faculty in ACLS and serves on Georgia Heart Association's CPR (cardiopulmonary resuscitation) task force.

Registration is limited to 48 physicians, and the fee is $160. For more information, contact the Georgia Heart Association, 2581 Piedmont Road, NE, Atlanta 30324.

Noncarcinomatous "Apple Core" Lesion of the Colon

CHRISTINE MURPHY, M.D., PAUL HUTCHINSON, JR., M.D., *and*
CARL W. NICHOLS, M.D., *Atlanta**

DR. CHRISTINE MURPHY: The patient is a 63 year old male with a six month history of vague abdominal pain and 30 pound weight loss. The pain had been increasing in severity prior to admission. Review of systems revealed the patient was a diabetic. The physical examination was normal except for guaiac-positive stools. After the patient was admitted, a barium enema was obtained. Dr. Hutchinson, would you comment on these films?

Dr. Paul Hutchinson: The barium enema reveals a typical "apple core" lesion in the proximal limb of the splenic flexure (Figure 1). A 4-5 cm. narrowed segment of colon is present with shelving margins proximal and distal to the narrowed segment. The narrowed segment is eccentrically located and there is mucosal destruction of the involved segment. The findings are very typical of carcinoma of the colon. Two other possibilities are granulomatous colitis and ischemic colitis with stricture formation. Usually the ischemic stricture has gradually tapering margins with concentric narrowing of the bowel lumen and intact mucosa. Granulomatous colitis usually has skip lesions, longitudinal ulcerations and fissures.

In this case, the x-ray findings as well as the clinical presentation strongly favor carcinoma of the colon.

Dr. Murphy: The patient underwent surgery with resection of the transverse colon. Dr. Nichols, would you discuss the pathology?

Dr. Carl W. Nichols: The colonic specimen measured 37 cm. in length. An indurated area of mucosal ulceration measuring approximately 5 cm. in maximum dimension was present on the antimesenteric border (Figure 2). The margins were quite irregular and edematous. The remainder of the bowel mucosa was without lesion throughout. Microscopically, the lesion had histological characteristics much like a chronic ulcer of the stomach or bowel. Luminal patency was preserved in the small arterial branches in the submucosa although occasional small fibrin thrombi were present in more superficial areas. Sections of mesenteric artery proximal to the lesion had a patent lumen. The ulcer with associated inflammatory and reparative changes is probably of ischemic origin.

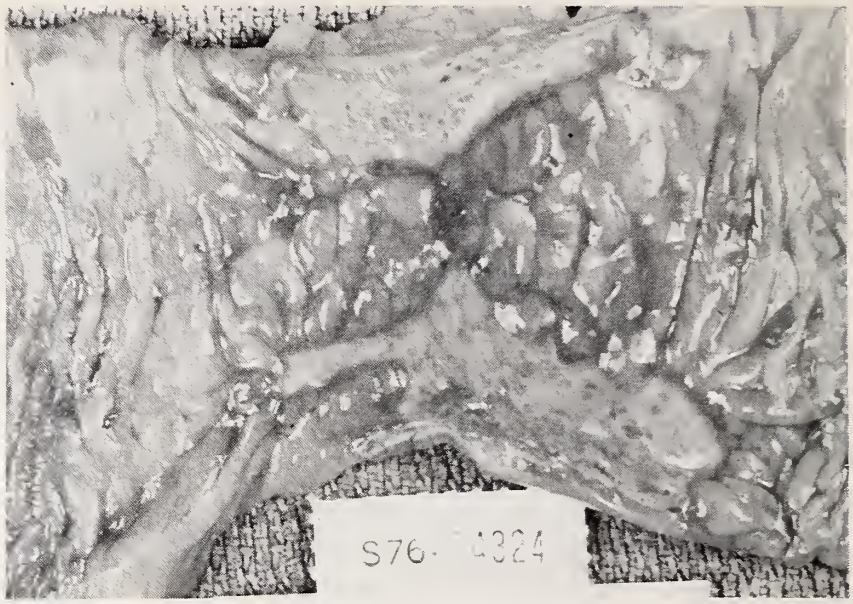


FIGURE 1
Pre-evacuation barium enema demonstrating constricting lesion in the proximal limb of the splenic flexure with shelving margins proximally and distally—a so-called "apple core" lesion.

* From a weekly x-ray conference of the Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Drs. J. L. Clements and H. S. Weens. Drs. Murphy and Hutchinson are from the Department of Radiology and Dr. Nichols is from the Department of Pathology at Emory.

FIGURE 2

Resected specimen demonstrating mucosal ulceration in a segmental ischemic lesion of the colon.



Comment and Review

In the colon, the most common areas of involvement with ischemic colitis are the distal transverse colon, the splenic flexure, and the cecum.[1] However, any segment may be involved.

There are three possible clinical effects of vascular occlusion to be considered.[2] If rapid occlusion of major blood supply to the intestine occurs, massive bowel necrosis and death from peritonitis and shock will result. If segmental vessels rather than a major trunk is occluded or if occlusion is slow or collateral circulation is adequate, infarction may not occur and complete healing may occur. The third possibility involves the situation where blood flow is adequate to prevent death of the intestine but recovery is not complete and fibrosis and stricture formation may develop.

The clinical features vary from a catastrophic event associated with extensive infarction to a very mild incident where the patient does not consult a physician and the event is recalled in retrospect when a lesion is demonstrated on barium study.[2] Symptoms include sudden onset of abdominal pain, vomiting, fever, and passage of blood per rectum.

Several reports including a recent report by Wittenberg et al.[3] have found the majority of patients with spontaneous ischemic colitis do not have major vessel occlusive disease. The results suggest that spontaneous ischemic colitis is likely secondary to alterations in flow or perfusion within the bowel wall.[3] The symptoms are usually very mild and may be completely ignored by the patient. This is in contrast to a second category termed acute extensive bowel ischemia.[3] This is primarily a disease of superior mesenteric artery distribution. It is frequently associated with congestive heart failure, digitalis toxicity, and/or peripheral occlusive arterial disease. The clinical presentation is much more severe and may be complicated by peritonitis and shock with a very poor prognosis.

If a barium enema is performed early, marked spasm with difficulty in filling the colon may be encountered. The mucosal folds are thickened and blunted and the bowel lumen is narrowed. "Thumbprinting" may be detected on the plain film but may be better appreciated on the barium study. Although ulcerations are frequently seen on pathological specimens, they are usually very superficial and rarely demonstrated on barium enema. Later fibrosis and stricture formation may occur. The stricture has a concentric lumen with smooth tapering contours and is commonly three to four inches long. The sequence from spasm and edema to stricture formation may occur over a period of several weeks.[2]

The differential diagnosis includes carcinoma and granulomatous colitis.[1] Carcinoma is usually excluded by the lack of overhanging margins and the eccentric lumen with mucosal destruction of the involved segment. In granulomatous colitis, longitudinal ulcerations, skip lesions, and fissures are frequent findings not seen in ischemic colitis. ■

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Looking Ahead to the 1977 General Assembly

JANUARY 10 MARKS the beginning of the 1977 Georgia General Assembly. This session of the legislature and the ones to follow will be of greater importance to the practicing physician and his patient than all past years combined.

As chairman of your State Legislative Committee, I am proud to say this committee and its staff have been hard at work during the summer and fall on legislation which will be introduced during this session. There are also two dedicated MAG members who have made the supreme sacrifice to run for public office and are now members of the Georgia House of Representatives.

Wilbur E. Baugh, M.D., P.O. Box 926, Milledgeville, 31062, whose specialty is radiology, is now in his second term of office.

J. Roy Rowland, Jr., M.D., Medical Center, Dublin, 31021, a family physician, is in his first term as a state representative.

Mrs. Cathey Steinberg, 3231-B Buford Highway, Atlanta, 30329, is in her first term as a state representative. Mrs. Steinberg is the wife of David L. Steinberg, M.D., internist.

Max R. Looper, P.O. Box 57, Dawsonville, 30534, is in his first term of office and is the brother of Ben K. Looper, M.D., obstetrician/gynecologist.

Kenneth W. Birdsong, 820 Gray Highway, Macon, 31031, also is in his first term as a state representative. Birdsong is the brother of William R. (Bill) Birdsong, M.D., pediatrician.

State Senator Paul Broun, 165 Pulaski Street, Athens, 30601, is the father of Paul Broun, M.D., neurosurgeon, of Americus.

If we, interested Georgia physicians and MAG members, initiate and maintain good communication with these people and with our own state representative and state senator our *voice will be heard* on all legislation. Please, for your sake and mine, do not procrastinate on getting involved any longer. Your thoughts and actions are needed—our legislators want to hear from you.

The Doctor-of-the-Day Program which MAG sponsors is the best single public relations program we have tried in a long time to involve physicians and inform legislators. A medical aid station is staffed by a full time nurse and a volunteer MAG member daily to take care of the medical needs of our lawmakers. Every day the physician is introduced before the House of Representatives and the Senate and is available for their health needs for that day. If you are interested in volunteering your services for a day, contact Rusty Kidd at MAG headquarters.

Major Upcoming Bills

At the writing of this article I am aware of several bills which will probably be introduced during the 1977 legislative session. They are, in alphabetical order:

Certificate of Need: MAG has successfully opposed this legislation in the past. The earlier bills mandated that every person or group who wanted to build, expand or renovate a hospital or nursing home had to get permission from DHR first. Federal legislation passed two years ago requiring all states to

pass Certificate of Need legislation to conform with federal law in order for the state to obtain certain federal monies. MAG will keep a close watch on this to make sure it goes no further than meeting the federal law.

Chiropractic: Legislation has been introduced in the past to mandate inclusion of chiropractic services under *all* health insurance policies. This will be introduced again. We are informed that the chiropractors will introduce legislation to permit them to use acupuncture and to take blood samples in their offices. MAG opposes all of these.

Confidentiality of Medical Information: MAG attorneys currently working are drafting a bill which would make the relationship between doctor and patient more confidential than it is at present. We hope to pass a law similar to the one governing the relationship between psychiatrist and patient.

Driver's License Act: Current law says physicians shall report to the Department of Public Safety all those persons who have an injury or illness which may limit their ability to drive an automobile safely. MAG will request legislation changing the word shall to may.

Drug Substitution: Legislation was introduced two years ago (successfully defeated by MAG) which would take the care of the patient away from the physician. Currently when a physician writes a prescription, the pharmacy has to fill it as written or get permission from the doctor to substitute another drug. Bills will be introduced next year to try to change this to say every prescription shall be filled with the least expensive drug regardless of what the physician has prescribed. MAG will oppose this legislation.

Health Maintenance Organizations: MAG in the past, although not opposing the concept of HMOs has successfully opposed the bills which contained a number of adverse sections. MAG attorneys are currently drafting a bill which MAG will sponsor to include those aspects which we think would make good legislation for the people of Georgia.

Hospital Privileges: MAG spoke in favor of this bill for the past two years. The bill passed, but a vital portion was deleted. The deleted portion, which MAG and the Board of Medical Examiners favored, would require all hospitals to report to the Board all physicians whose hospital privileges were suspended or revoked.

Hypnosis: MAG will seek passage of a bill limiting the use of hypnosis to physicians, dentists and licensed applied psychologists.

Malpractice: MAG will continue to try and make our good laws better. We now have the best malpractice laws in the country. We will try to pass the following in 1977: arbitration; collateral sources of income; reporting all judgments in excess of $10,000 to the Board of Medical Examiners.

Medical Practice Act: Several bills will probably be introduced dealing with Georgia's Medical Practice Act. Current law is good—it has ample enforcement provisions while at the same time it gives the Board of Medical Examiners ample leeway to reprimand. The number one objective of new legislation is to get more of the money generated by the Board returned to it. Currently the Board generates $600,000 per year in license fees, etc. Approximately 50 per cent of this is returned for the operation of the Board. With additional money the Board will be able to hire more investigators which will enable it to operate more efficiently.

Optometry: The optometric profession was successful last year in passing a modified version of their "freedom of choice" legislation. We are informed that in 1977 they will introduce a bill giving them the right to use diagnostic drugs which by current statute and training they are neither licensed nor qualified to do. MAG probably will oppose this legislation.

James A. Kaufmann, M.D.
Chairman, State Legislative Committee

president's letter

December of 1976



"CHRISTMAS IS for children." Isn't it nice to be a child with long legs? Sure mother and wife will be "basket cases" on the 26th, but they are the ones who survived.

Hanukkah and Christmas, I salute you. May those events be worthy in each heart as one feels best.

Recently we again were privileged to view "Gone With the Wind."

The wind, Christmas, and Hanukkah.

Georgia birthed its first president in 1976. Fascinating for sure the folks that have elected our next president. The Wind is gone, or is it?

The relatively fixed physician of Georgia may look upon his plight in many different prospectives this December, 1976.

Yes, Christmas is for children. I hope none of you grow old in heart—"worm surgery" or otherwise.

Isn't it fascinating where the years exist as we lengthen the span of life on this earth.

Who said it first? "You made your own bed, now sleep in it!"

My personal invitation with best wishes for your own joyous observance of the Yuletide.

Sincerely,

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

heart page
heart page
heart page

Review of Hypertension and Hypercholesterolemia in Children

Part 2

KENNETH J. DOOLEY, M.D., *Atlanta**

HYPERTENSION, ALTHOUGH a new field in pediatrics, is not the only adult problem that is being passed on to the pediatrician and family physician. Hypercholesterolemia and hypertriglyceridemia are slowly being recognized as a growing problem. The fatty streaks of future atheromatous plaques have been found at post mortem in children as young as 3 to 5 months. Some of these may be absorbed but others surely go on to form the pathologist's friend—atheroma.

As with hypertension the normal values for hypercholesterolemia and hypertriglyceridemia are as yet not firmly established for children. Numerous studies and reviews have been done—Lauer et al.,[3] Lloyd,[7] and Glueck[8] in an attempt to outline criteria for what normal values may be. In Lauer's[3] report the mean serum cholesterol level was 182 mg% (±29) and he found that serum cholesterol levels were similar for children of all ages. The review involved a 14 month study of 4,829 school children in Muscatine, Iowa. The serum triglyceride level was found to vary with age. The mean level by age six was 71 mg% (±36) and 108 mg% (±45) by age 18. In his study, 37 percent of children were found to have cholesterol levels above 200 mg% and 15 percent had serum triglycerides about 140 mg%. These values are very similar to values found in studies by many others concerning cholesterol levels in children in the United States. These levels are not universal however, as Scrimshaw et al.[9] and Golubjatnikov et al.[10] have reported that rural and lower income families may have cholesterol levels 20 to 50 percent lower than the values seen above. From this, one must conclude that environment and, most likely, diet play an important role and that coronary artery disease may be a preventable disorder.

Hypercholesterolemia is known to occur in nephrotic syndrome, uncontrolled diabetes mellitus, untreated hypothyroidism and in certain stages of glycogen storage diseases. Control and treatment of these disorders will usually bring the cholesterol levels under control. Of the familial hyperlipidemias, Burger-Grutz or fat induced hyperlipidemia, is the type most commonly found in children. The lastescence of their serum will usually clear on a fat free diet but their triglycerides remain elevated. This however, makes up a very small percentage of children with hypercholesterolemia and the heterogenous group of familial hyperlipidemia, hypercholesterolemia and combined hyperlipidemias may be present.

Routine screening for hypercholesterolemia and hypertriglyceridemia is not recommended at this time. However, because of the presence of familial hypercho-

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Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

lesterolemias, one would be well advised to obtain levels for cholesterol and triglycerides in children of families with strong history of coronary artery disease especially if the disease is being diagnosed because of myocardial injury before age 50. Glueck et al.[11] and Tamir et al.[12] have shown that 35 percent of children have familial hypercholesterolemia if a history of myocardial infarction before age 50 was found in parents. Diagnosis of familial hypercholesterolemias is usually not difficult. To establish the diagnosis, plasma for cholesterol triglycerides and lipoprotein electrophoresis is drawn following a 12 hour overnight fast while on regular diet. Any cholesterol level greater than 200 mg% deserves following and, if greater than 240 mg%, treatment should be instituted. The choice of therapy is rather unsettled but diet and cholestyramine are the two present modes recommended. Again, as in hypertension, one may do the patient the most good by instituting treatment in cooperation with a consultant in this field in order to allow for the most effective use of the results obtained.

It has recently been recommended by the Atherosclerotic Study Group of the Inter-Society Commission for Heart Diseases Resources[13] that dietary restriction be started in infancy. They suggested that (1) caloric intake be adjusted to maintain weight within normal ranges for age, sex and height, (2) dietary cholesterol be restricted to 300 mg/day, and (3) intake of dietary saturated fats be reduced to less than 35 percent of caloric intake. The Committee on Nutrition of the American Academy of Pediatrics[14] and the Council of Rheumatic Fever and Congenital Heart Disease of the American Heart Association[15] have taken exception to this statement, stating that the scientific evidence was not sufficient to justify a general recommendation such as stated above.

It is advised that with obesity and cholesterol being influenced directly by dietary intake, one should have available literature on proper nutrition as well as stressing exercise and refraining from smoking in pediatric practice. ■

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More on Certificate of Need

J. WINSTON HUFF, *Atlanta**

LAST MONTH we dealt with the effect of Public Law 93-641, the National Health Planning and Development Act of 1974 (the "Act") as regards certificate of need legislation. It was pointed out in that article that those states which do not now have a certificate of need law will be forced to adopt one or face the loss of federal health funds. What will be discussed here is how and by whom the certificate of need process will be fashioned in the event that the Georgia General Assembly should in the future adopt a certificate of need law.

A brief background is needed. The Act (Public Law 93-641) requires the establishment of Health Service Areas "throughout the United States." Each Health Service Area is to be a "geographic region appropriate for the effective planning and development of health services, determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area." There are other requirements to be met, such as minimum and maximum population in an area. The Governor of each state has the right, with approval of the Secretary of HEW, to designate the Health Service Areas within his state. This has already been done in Georgia, which has been divided into six Health Service Areas with extreme northwest Georgia being incorporated into the Chattanooga, Tennessee, area.

The Act also authorizes the creation of a Health Services Agency ("HSA") for each Health Service Area. The HSA is the most local body or group functioning under the Act. The Act prescribes what group or entity may become an HSA, the size and expertise of the professional staff, the composition of the governing body and what responsibilities that governing body shall have. A majority (but not more than 60 percent) of the HSA governing body must be residents of the area, must be consumers of health care and not providers of health care. The remainder of the governing body is to be representative of physicians, dentists, nurses and other health care professionals, health care institutions and facilities, health care insurors, health professional schools and allied health professions. The duties and functions of an HSA are set forth, including improving the health of residents of the areas, increasing the accessibility and quality of health services, "restraining" increases in the cost of health services, preventing unnecessary duplicating of health resources, and assembling and analyzing data.

Each HSA must "establish, annually review and amend as necessary" a Health Systems Plan ("HSP"). The HSP is a statement of goals for healthful environment and health systems which will assure that quality health services will be available and accessible at reasonable cost for the area's residents. The HSP must be responsive to the needs and resources of its area and must be consistent with the national health guidelines developed on a national scale. A public hearing must be held giving interested persons an opportunity to submit their views before an HSP

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

is adopted. The HSA must also "establish, annually review and amend as necessary" an Annual Implementation Plan ("AIP") describing objectives to achieve the HSP goals. Certain other prescribed duties must be carried out including coordination of activities with the Professional Standards Review Organization ("PSRO") in the area.

As soon as possible after the establishment of the Health Service Areas, the Secretary of HEW is to enter into agreements for the designation of HSAs for each area. Planning Grants can be made available to the HSAs.

In each state there is superimposed over the HSAs a State Health Planning and Development Agency ("State Agency"). The State Agency is designated by an agreement between the Secretary of HEW and the Governor of the state. The State Agency must devise a State Administrative Program (the "State Program"). The State Program will provide for the performance of the functions prescribed by the Act. It must also be supported by "satisfactory evidence" that state law authorizes the carrying out of all such functions.

Among the prescribed functions for the State Agency is the administration of a "State certificate of need program" applicable to new institutional health services proposed to be offered or developed within the state. This program must be satisfactory to the Secretary of HEW. The certificate of need program must provide for review and determination of need prior to the time services, facilities and organizations are offered or developed, or substantial expenditures are undertaken, and the program must provide that only those services, facilities and organizations found to be needed shall be offered or developed within the state.

How, then, will a certificate of need program be evolved, assuming the Georgia General Assembly adopts such a law? Both the State Agency and the HSAs within the state will be involved in determining the state's certificate of need program. The Act places the administration of the certificate of need program in the hands of the State Agency. However, the HSAs within the state also play an important role in this process. As we have seen, each HSA in each area is required to establish and review a Health Systems Plan and an Annual Implementation Plan. The HSP must set goals for its area to insure quality health services are available and accessible, and to insure continuity of care at reasonable cost. Thus it would appear that the initial planning for health care and facilities, including a determination of need, begins with the HSA determining what the needs in its area are.

The final decision rests with the State Agency, but in making that decision the State Agency must take into account the Health Systems Plans of the state's several HSAs. The statute requires that in "performing its functions" pertaining to the certificate of need program the State Agency must "consider the recommendations" of the HSAs. Further, one of the duties of an HSA as set forth in the Act is to assist the State Agency in carrying out its certificate of need function and to make recommendations to the State Agency "respecting the need for new institutional health services proposed to be offered or developed" in the Health Service Areas. The Act also provides that if the State Agency makes a decision as to the certificate of need program which is inconsistent with a recommendation made by an HSA, then the decision of the State Agency is subject to review under an appeal mechanism consistent with state law governing administrative agencies. The Act also prescribes criteria which the HSAs and State Agencies must apply in their review functions. The very first criteria is "The relationship of the health services being reviewed to the applicable HSP and AIP." Finally, the Act requires certain "due process" safeguards in the review procedures, including notification to affected persons and provisions for public hearing.

Thus the Act, in the area of certificate of need alone, represents an enormous change in the way health facilities and services funded with federal dollars will be planned and provided. As was stated in last month's article, the Act is under attack in several test cases. It is quite probable that a good deal of additional litigation will result from this law before all the questions it presents are settled. ■

I've told this before . . . .

(Ed. note: A practical lesson in solving one of life's dilemmas is taught to a retired professor in this Christmas season story by J. G. McDaniel, M.D. Others wishing to submit material for this page should contact the Journal of the Medical Association of Georgia *at 938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

You've Got to Think

Zeb McDaniel from Albany, Georgia told me a story some weeks ago that will strike a responsive cord with many fathers and grandfathers.

It seems that some years ago a retired professor of nuclear physics had moved to a fairly small town in Georgia. It had been a very difficult decision for him to make, especially since most of their friends were connected with the university in one way or the other. He and his wife, however, were each brought up in small towns and now that their children were all grown and away, they kept thinking of an unsophisticated life in a small home with a garden for vegetables and flowers.

The chief reason for the selection of this little city was the fact that his favorite daughter and her three children lived there. And, if he had a favorite grandchild, it was her six year old son, who had been named Albert for his grandfather.

Albert was a brilliant, uninhibited towheaded youngster whose mind and body always seemed to be in fourth gear. And it didn't matter what the old professor was doing, when Albert came in on Cloud 9, with his incessant prattle, he set his work aside and his face radiated pure joy.

Christmas was approaching and grandfather learned that he wanted a Bat Cave for use by the Batman. Unfortunately, a Bat Cave was not available in town, but one store was kind enough to order one. It arrived in about a week, but had to be assembled. This should be an easy task, however, since instructions were given in detail and a picture of the assembled Bat Cave was given.

For some reason, it was not so easy as it appeared at first glance. Each time he assembled it, he had parts left over, or parts would not fit. Exasperated, he called Albert's father and explained his predicament. Albert's father set his straight in just a few minutes. He said that he had long since had the course in this kind of thing and that now he never bought a toy or anything else that was not ready to use. He did suggest, however, that he might take it down to "Uncle Mose" who was a sort of Jack of all trades and had helped him with similar problems over the years.

The professor arrived at Uncle Mose's shack. He saw the old man through the window, sitting by a table and sanding an axe handle. He had to beat on the door a good long time before he could attract his attention because Uncle Mose was about "half deaf."

Old Mose cleared off one end of the table and emptied out all the pieces. Then sat down and studied the picture. Despite urgings, he scarcely glanced at the instructions. After some 10 minutes of looking first at the picture and then at the parts, he commenced putting it together and within another 10 minutes it was assembled perfectly.

"You know something," said the retired professor of nuclear physics to Uncle Mose, "I do not understand how you accomplished something in 20 minutes that I could not accomplish all afternoon."

"Well, I tell you something, boss," answered Uncle Mose, "When you can't half hear, and you can't half see, and you can't read, ner write, you haff's to learn to think!"

J. G. McDaniel, M.D.
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SOCIETIES

Members of the Bibb County Medical Society and its Auxiliary enjoyed a joint meeting in November. Auxiliary member Mrs. Robert S. (Nony) McMichael presented a program on "Little Stories About Our Doctors" followed by an evening of dancing. The society's nominating committee has proposed the following slate of officers for 1977: Hugh F. Smisson, president; Alex Weaver, president-elect; Beverly B. Sanders, vice president; Rodney Browne, vice-councilor; Alva Mayes, board of trustees; Milledge Newton, delegate to MAG; Rex Tidwell, judicial council; Joe Shields, long-term planning committee.

The Auxiliary to the Bibb Society was featured in a recent article in the *Macon Telegraph* listing their accomplishments and projects. The women have a health education project which has involved the production of a portable exhibit on the eye to be viewed by school children, and subscriptions to *Todays Health* (now *Family Health)* have been given to 15 area schools. A film on venereal disease is being circulated to junior and senior high schools and a skit on nutritional needs, "You Can't Fool Mother Nature," is being shown. Funds for the AMA-ERF will be raised by the sale of Christmas cards, an annual tasting luncheon, tennis clinic and tournament.

The Cobb County Medical Society helped plan a minisymposium December 2 at Kennesaw Junior College titled "Are We Sick Because We Want to Be?" Charles R. Underwood of Marietta served as moderator of a "reaction panel" with Connie Conrad of Emory University as one of the panel members.

Newly elected officers of the Cobb society are: Dan Stephens, president; Philip Israel, president-elect; and Evans Nichols, secretary-treasurer.

A joint meeting of the DeKalb Medical Society and the Decatur-DeKalb Bar Association November 20 was highlighted by an address by Gov. George Busbee.

The October meeting of the Georgia Medical Society included a program on "The Visual System of Sharks and Their Behavior" given by Dr. Samuel H. Gruber, associate professor of marine sciences at the University of Miami, who also showed a film on sharks, "Danger in the Sea."

The Hall County Medical Society met with Ninth District Congressional candidate Mrs. Louise Wofford at their September meeting. For future meetings, the society hopes to arrange a joint program for the medical and legal communities and a Christmas dance. The Emergency Medical Care Committee of the Hall County Society is meeting with the county commissioners to plan emergency care for the area.

The Muscogee County Medical Society invited William W. Moore, chairman of the MAG Insurance Committee to speak at their October meeting, and in Novem-

ber they heard from Jack Brinkley, congressman from the Third District. In January the speaker will be J. Rhodes Haverty, former MAG president, and dean of the School of Allied Health Sciences at Georgia State University in Atlanta.

PERSONALS

First District

A. B. "Bird" Daniel, retiring Statesboro physician, was featured in an October full page story in the *Statesboro Herald.* He reminisced about the "kitchen table surgery" of the '30s and '40s, his experience as an army surgeon in World War II Europe, and concludes from his years of medical experience that a physician must be a counselor and advisor as well as healer.

Third District

Robert D. Marcus of Columbus has been installed as a Fellow of the American College of Surgeons. He participated in a ceremony held in Chicago in mid-October.

Dawson physician Walter Martin has been honored by the Terrell County Hospital Authority for his service to the community and hospital, on whose staff he has been since 1951.

Donald M. Stewart of Columbus, president of the Georgia Society of Anesthesiologists, has attended the annual meeting of the American College of Anesthesiology in San Francisco.

Fourth District

New staff officers at DeKalb General are: Clyde Rountree, chief of staff; Ralph Tillman, vice chief; and William Ward, secretary. Department heads are: George Sessions, anesthesiology; Tom Lowry, emergency medicine; Ed Galler, internal medicine; Byron Dunn, ob-gyn, Frank Matthews, pathology; Jordan Dean, pediatrics; Frank Morgan, radiology; Ellis Keener, surgery; James Bowcock, psychiatry.

Fifth District

Eugene J. Gillespie has been appointed medical director of Prudential, replacing Joseph Read, who will retire at the end of 1976.

Carl Hartrampf, Atlanta plastic surgeon, is the new chairman of the Northside Hospital medical staff.

A Letter to the President

Dear Dr. Jolley:

I have never thought very much about growing old, but suddenly I wake up to find that I have reached the age of 90. You know you are getting old when after painting the town red you need a long rest before the second coat. I am almost half as old as these United States in which we live.

When I stop to think, I realize that my life thus far has been through a wonderful age. More progress has been made in the last 90 years than in any other period of that length. In 1886 the medical profession still thought the cause of diseases was "spontaneous generation," that is, the disordered conditions in your body determined the disease that would attack you. At that time there were four main diseases: 1) throat distemper (diphtheria); 2) lung rot (tuberculosis); 3) putrid fever (typhoid); and 4) smallpox.

They did not know that a specific type of germ caused each disease. Louis Pasteur of France made this discovery a short time before, but the United States were skeptical about it and some of them had never heard of such a thing. It was several decades before the profession accepted Pasteur's ideas and shaped their practice accordingly. A few scientists in various countries took up the study of bacteriology and made many discoveries. For example, a German, Dr. Koch, discovered the Tubercular Bacillus in 1888; two other Germans, Klebs and Loeffler discovered the Cholera Bacillus in the nineties, and made a vaccine to counteract the disease. To make a long story short, Pasteur's discovery and the subsequent pursuance of his theories has conquered infectious diseases to such an extent that now a person can grow from babyhood to adulthood and escape measles, mumps, whooping cough, diphtheria, thyphoid, tuberculosis and all other infectious diseases. Quite an accomplishment.

Amazing accomplishments have been made in all other lines. For example, speed of travel has jumped from 60 m.p.h. (train) to 2,000 m.p.h. in our atmosphere and 15,000 m.p.h. in space. Earth broadcasting stations together with satellite stations can flash news worldwide in seconds. Artificial ice was made in Appalachicola, Florida just a few years before I was born. So was the bathtub (1850) and the telephone in 1875. If I had lived a few years earlier I could have taken a bath without fear of having the telephone ring.

By the mercy of God I have lived a long life and I am very grateful for this blessing. I have a lot of wonderful friends and I appreciate you more than I can express. I am too old to set a good example but am open to give advice any time.

Devotedly,
Zach Cowan
1179 Clifton Road, N.E.
Atlanta, Georgia 30316

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

The post-Watergate 94th Congress, on paper the most liberal Congress in recent history, refused to adopt any major new federal ventures into the health field.

Nor did the lawmakers vote to impose added controls on providers in an effort to get a handle on soaring costs.

The final status of selected major health and health-related legislation in the 94th Congress is reviewed in Table 1.

Two important bills bit the dust. One, the Clinical Laboratory Improvement Act, would have set up strict federal standards and licensing for clinical laboratories. The other, the Medicaid Fraud and Abuse Bill, would have strengthened the Health, Education and Welfare Department's policing of Medicaid abuse and increased penalties for violations. Both of these bills cleared Senate and House committees, but backers were unable to salvage them in the torrent of last-minute action on legislation.

Squeaking through during the final days were bills to set up an Inspector General at HEW to oversee fraud and abuse, especially in medical programs; to continue federal assistance to help states and localities establish emergency medical systems; and to broaden federal aid for Indian health.

Casualties included bills to impose stricter clean air standards, to revise the lobbying laws to require additional reporting; and to change the way the government issues regulations to carry out laws.

Education Assistance Act

The three-year, $2 billion aid-for-medical education bill has been signed into law by President Ford who said it "virtually assures that no individual will be denied a medical education for financial reasons."

The Health Professions Education Assistance Act creates a new Health Professions Student Loan Guaran-

TABLE 1

Subject; Number	House, Senate Action: Committee	House, Senate Action: Floor	Conference	Presidential Action
1. Manpower				
HR 5546	6/ 7/75	7/11/75	Completed; sent to White House	PL 94-484
S 3239	5/14/76	7/ 1/76 (HR 5546)		
2. HMO Amendments				
HR 9019	8/26/75	11/ 7/75	Completed; sent to White House	PL 94-460
S 1926	5/13/76	6/14/76 (HR 9019)		
3. CLIA				
HR 14319	9/ 8/76	—		
S 1737	4/26/76	4/29/76 (Died)		
4. Indian Health				
HR 2525	4/ 9, 5/10,	7/30/76 (S 522)	Avoided; sent to White House	PL 94-437
S 522	5/12/76			
	5/13/75	5/16/75		
5. EMS (and biomedical research)				
HR 12664	5/ 5/76	8/24, 10/1/76	Avoided; sent to White House	PL 94-573
S 2548	5/14/76	6/10, 10/1/76 (S 2548)		
6. HEW Appropriations				
HR 14232	6/ 8/76	6/24/76	Completed; sent to White House; vetoed	Veto overridden; PL 94-439
S-HR 14232	6/26/76	6/30/76		
7. Lobby Reform				
HR 15	9/ 2/76	9/21/76 (Died)		
S 2477	4/26/76	6/15/76		
8. Admin. Rule-making				
HR 12048	4/ 6/76	Suspension vote failed (Died)		
S 3297	Pending			
9. Medicare, Medicaid Reform Act				
HR 13080	Pending	(Died)		
S 3205	Pending			
10. NHI				
HR—various	Pending	(Died)		
S —various				
11. HEW Inspector General (rider)				
HR 11347	—	9/29/76 (House) 9/28/76 (Senate)	None needed; sent to White House	PL 94-505

tee Program and a Loan Insurance Fund through fiscal 1978.

It continues and expands current medical scholarship programs. In return, recipients will be required to serve in a health manpower shortage area for at least two years.

In a statement released with the signing, Ford said a government study had shown "there were alarming signs that this country was facing two growing problems: 1) Not enough doctors in rural and inner city areas; 2) A continuing decline in the number of doctors practicing primary care because too many medical students are specializing instead of becoming general practitioners.

The bill requires medical schools receiving government capitation grants to provide annually an increasing percentage of residency positions for individuals in primary care specialties such as internal medicine, pediatrics and family medicine.

The compromise legislation strengthens the National Health Service Corps. Before passage, the measure was stripped of many federal control provisions fought by the American Medical Association.

HMO Laws Relaxed

President Ford has also signed into law a bill designed to stimulate establishment and growth of Health Maintenance Organizations (HMOs). Thrust of the new law is to relax many previous restrictions on HMOs including the requirement that they must have "open enrollment" so that everyone could join regardless of health or financial circumstances.

The required benefit package was trimmed slightly, but the final version of the measure retained the requirement that rehabilitative treatment for alcoholism and drug abuse be offered. The old ban on private physicians participating in an HMO on a part-time basis was lifted. The law makes it easier for HMOs to receive federal financial assistance.

The AMA had contended that effect of the legislation was to negate the original concept of the HMO as a new type of delivery system open to everyone and to distort the program into a simple subsidy for prepaid group practice plans.

The new law permits:

HMOs to contract directly with individual practitioners or groups of health professionals that do not qualify as medical groups or individual practice associations provided that the amount of services so contracted for does not exceed 30 percent of the the dollar value of the total physician compensation paid by a rural HMO, or 15 percent of such dollar value in the case of a non-rural HMO.

A previous requirement for medical groups that provide care for HMO enrollees is that the provision of such care must be the group's "principal professional activity." The bill provides that, for a three-year period, the HMO could provide services through medical groups whose members do not offer such services as their principal professional activity. After the three-year period, only medical groups whose members have a substantial responsibility for the delivery of services to HMO enrollees could be utilized. Substantial responsibility is defined as devoting at least 30 percent of the health professional's time to such enrollees.

Health Care Spending

Total spending on health care in this country is estimated to jump from the current $140 billion to $223.5 billion in five years, according to an actuarial study prepared for HEW.

The study, which figures to be often-cited during next year's Congressional consideration of National Health Insurance (NHI) proposals, also predicts that any NHI plan will add at least $10 billion to the overall expenditures on health. The "induced" spending would come from "encouraging more use of health services covered by the plan, adding administrative expenses for the extra insurance and paying for bad debts and charity services," among other factors, the report said.

The spending impact was compared of six major NHI plans—those of the AMA, the American Hospital Association (AHA), the Health Insurance Association of America (HIAA), the Labor-Kennedy forces, Sens. Russell Long (D-La.) and Abraham Ribicoff (D-Conn.), and the Nixon Administration (CHIP).

The Gordon R. Trapnell actuarial firm forecast that the Long-Ribicoff measure focusing on catastrophic expenses would add the least to overall health spending by fiscal 1980 if put into effect next year—$9.8 billion.

Next on the list was the plan by the health insurance companies—$11 billion, followed by CHIP, $11.3 billion; the AMA plan, $20.3 billion; the Labor-Kennedy Program, $24.8 billion; and the AHA plan, $25.1 billion.

The study said Long-Ribicoff, CHIP, and the HIAA plans "tend to use a variety of cost-sharing mechanisms, limit preventive services to children, and concentrate most of their additional spending on the poor, while the AMA, AHA, and Health Security (Kennedy-Labor) proposals tend to have little or no cost-sharing, provide preventive services to everyone, and increase insurance coverage broadly for the general population."

Laetrile Question

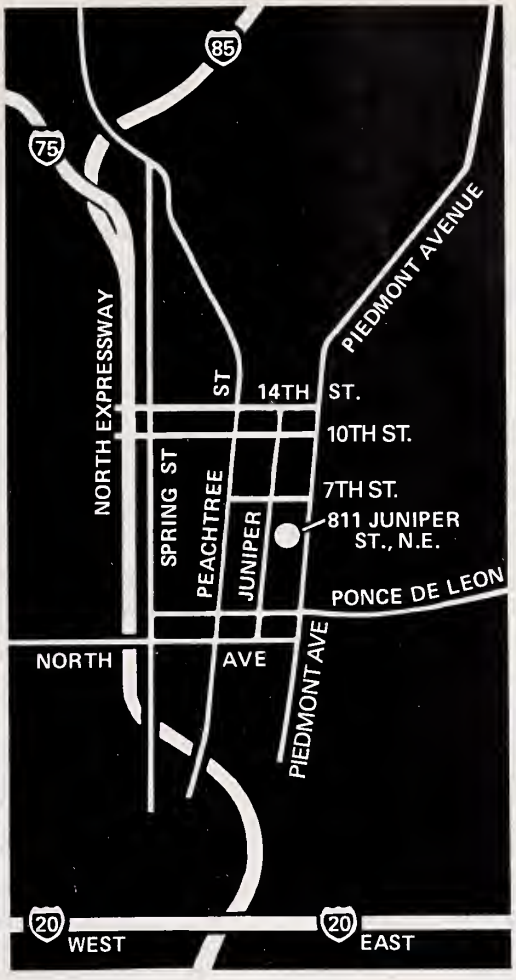
The government's powers to move against quack remedies suffered a setback when the Federal Appeals Court in Denver, Colo. recently refused to overturn a District Court decision allowing a cancer patient to buy and transport the questionable anti-cancer product, Laetrile.

The Appeals Court did not rule on the question of whether Laetrile was effective or whether the Food and Drug Administration had the right to bar it from the market. The FDA record on Laetrile was "grossly inadequate," the Court said. "The question whether this is a new drug presents a mixed question of fact and law which should be fully tried," said the Appeals Court. The FDA was ordered to "develop a record supportive of the agency's determination."

The FDA had no immediate comment on the decision. Staff lawyers were unsure how to proceed. However, the Appeals Court muddied the waters on the legal statutes of the controversial drug which has served as a focus for complaints that FDA is overstepping its authority in cracking down on non-authorized drugs or products.

An Oklahoma City District Court judge had ruled earlier that Laetrile was effective and that the FDA was acting unconstitutionally in seeking to prohibit it.







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- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

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edical Director

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OFFICERS

Position		*Term Ending*
* President	Fleming L. Jolley, Atlanta	1977
* President-Elect	Robert E. Perry, Jr., Brunswick	1977
* Immediate Past President	David A. Wells, Dalton	1979
Past President	J. Rhodes Haverty, Atlanta	1978
Past President	C. E. Bohler, Brooklet	1977
* First Vice President	James H. Sullivan, Columbus	1977
* Second Vice President	Milton I. Johnson, Macon	1977
* Chairman of Council	Robert E. Perry, Jr., Brunswick	1977
* Secretary	Earnest C. Atkins, Atlanta	1978
* Treasurer	Carson B. Burgstiner, Savannah	1978
* Speaker of the House	L. C. Buchanan, Decatur	1977
* Vice Speaker of the House	Ronald F. Galloway, Augusta	1977
Editor, *JMAG*	Edgar Woody, Jr., Atlanta	1977

COUNCILORS AND VICE COUNCILORS

District	*Councilor*	*Vice Councilor*	*Term Ending*
1	Leon E. Curry, Metter	Charles R. Richardson, Statesboro	1979
2	J. Dan Bateman, Albany	Sammie Dixon, Tifton	1979
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1979
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1977
7	Don Schmidt, Cedartown	Richard A. Griffin, Cartersville	1977
8	Joe C. Stubbs, Valdosta	Fred C. Smith, Valdosta	1977
9	Harvey M. Newman, Gainesville	L. Austin Flint, Canton	1978
10	Edwin W. Allen, Jr., Milledgeville	M. A. Hubert, Athens	1978
Bibb County Medical Society			
	Milton I. Johnson, Macon	Beverly B. Sanders, Macon	1978
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1978
DeKalb Medical Society			
	Luther M. Vinton, Avondale Estates	Stanley P. Aldridge, Decatur	1978
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Lee H. Battle, Rome	1978
Medical Association of Atlanta			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1977
	T. J. Anderson, Jr., Atlanta	William D. Logan, Atlanta	1978
	J. Harold Harrison, Atlanta	William C. Waters, III, Atlanta	1979
Georgia Medical Society			
	Joseph A. Mulherin, Savannah	Joe L. Nettles, Savannah	1979
Muscogee County Medical Society			
	Jack A. Raines, Columbus	Louis A. Hazouri, Columbus	1977
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Henry D. Scoggins, Augusta	1978

AMA DELEGATES AND ALTERNATE DELEGATES, JANUARY 1, 1977

Delegates	*Term Ending*	*Alternate Delegates*	*Term Ending*
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F. W. Dowda, Atlanta	12-31-77	Charles D. Hollis, Albany	12-31-77
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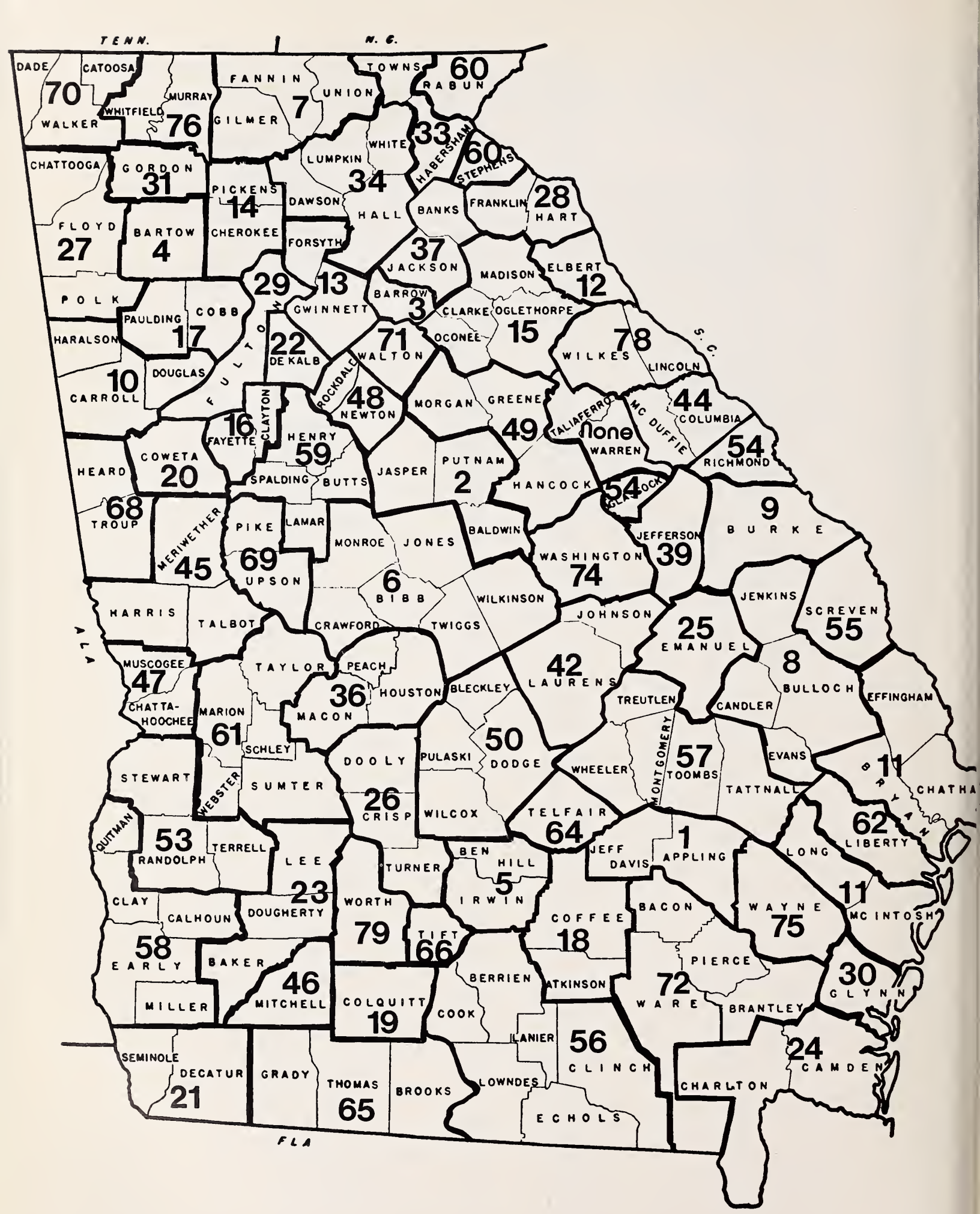
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PLASTIC SURGERY	**GEORGIA SOCIETY OF PLASTIC SURGERY** John Bostwick, Emory University Clinic, 1365 Clifton Road, N.E., Atlanta 30322
PSYCHIATRY	**GEORGIA PSYCHIATRIC ASSOCIATION** Joseph B. Baird, Jr., 1970 Cliff Valley Way, N.E. Atlanta 30329
PUBLIC HEALTH	**GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS** T. O. Vinson, District Health Director, DeKalb County, 440 Winn Way, Decatur 30030
RADIOLOGY	**GEORGIA RADIOLOGICAL SOCIETY** Richard S. Colvin, 1365 Clifton Road, Atlanta 30322
SURGERY	**GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS** Frank L. Wilson, 35 Collier Road, N.W., Atlanta 30309
UROLOGY	**GEORGIA UROLOGICAL ASSOCIATION** Tom Florence, 340 Boulevard, N.E., Atlanta 30312

County Guide List

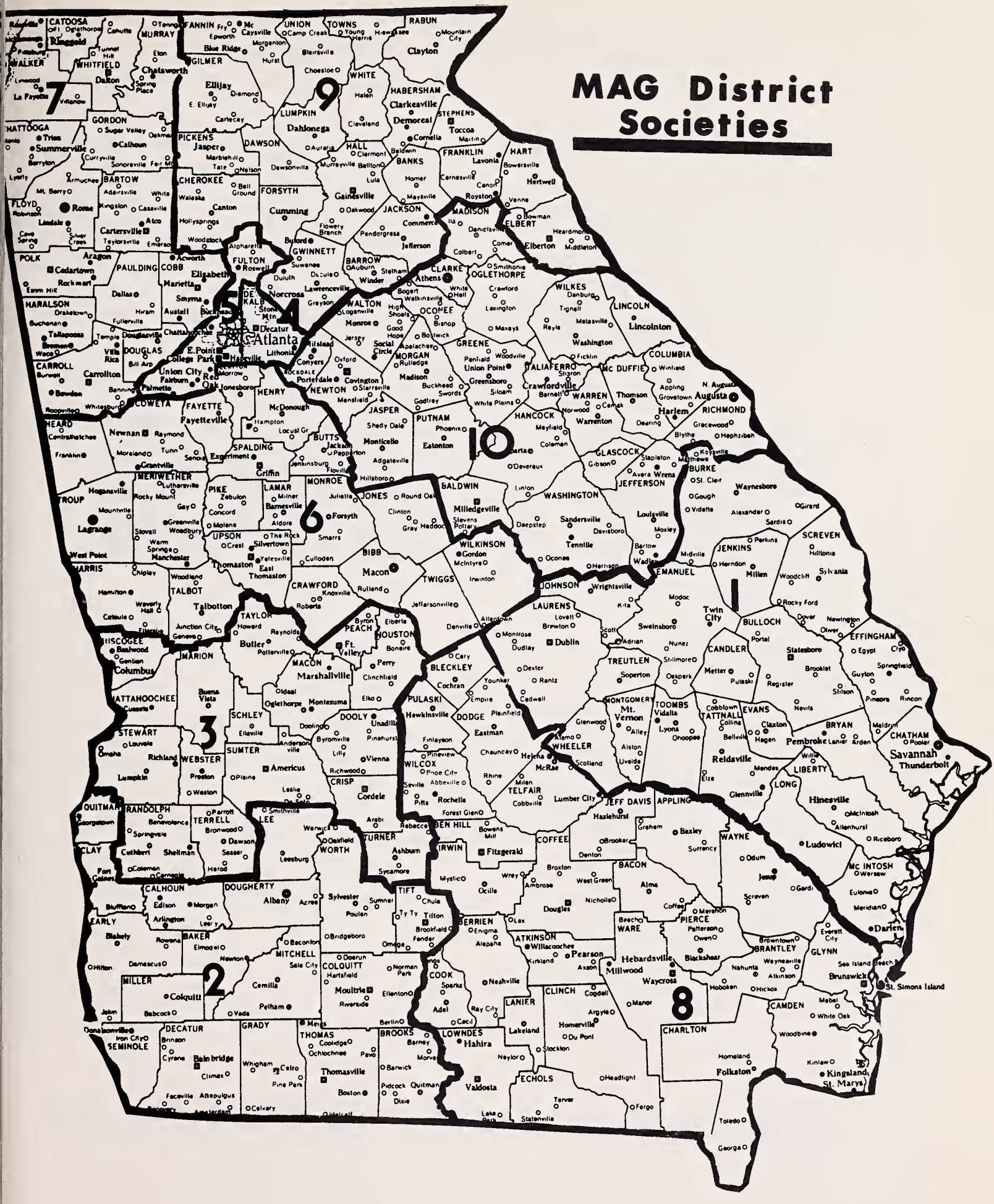
The following County Guide List is provided as an aid in locating a specific member physician. The first column lists the county in which he would practice; the second column indicates the number of the component county medical society in which he holds membership; the third column is the name of the component county medical society; and the fourth column gives the page number on which each component county listing begins.

County	County No.	County Medical Society	Page Number
Appling	1	Altamaha	84
Atkinson	18	Coffee	97
Bacon	72	Ware	140
Baldwin	2	Baldwin	84
Baker	23	Dougherty	102
Banks	37	Jackson-Banks	124
Barrow	3	Barrow	84
Bartow	4	Bartow	85
Ben Hill	5	Ben Hill-Irwin	85
Berrien	56	South Georgia	134
Bibb	6	Bibb	85
Bleckley	50	Ocmulgee	129
Brantley	72	Ware	140
Brooks	65	Thomas Area	137
Bryan	11	Georgia Medical Society	89
Bulloch	8	Ogeechee River	88
Burke	9	Burke	88
Butts	59	Spalding	135
Calhoun	58	Southwest Georgia	135
Camden	24	Camden-Charlton	103
Candler	8	Ogeechee River	88
Carroll	10	Carroll-Douglas-Haralson	88
Catoosa	70	Walker-Catoosa-Dade	139
Charlton	24	Camden-Charlton	103
Chatham	11	Georgia Medical Society	89
Chattahoochee	47	Muscogee	126
Chattooga	27	Floyd-Polk-Chattooga	103
Cherokee	14	Cherokee-Pickens	92
Clarke	15	Crawford W. Long	93
Clay	58	Southwest Georgia	135
Clayton	16	Clayton-Fayette	94
Clinch	56	South Georgia	134
Cobb	17	Cobb	94
Coffee	18	Coffee	97
Colquitt	19	Colquitt	98
Columbia	44	McDuffie	125
Cook	56	South Georgia	134
Coweta	20	Coweta	98
Crawford	6	Bibb	85
Crisp	26	Flint	103
Dade	70	Walker-Catoosa-Dade	139
Dawson	34	Hall	123
Decatur	21	Decatur-Seminole	98
DeKalb	22	DeKalb	98
Dodge	50	Ocmulgee	129
Dooly	26	Flint	103
Dougherty	23	Dougherty	102
Douglas	10	Carroll-Douglas-Haralson	88
Early	58	Southwest Georgia	135
Echols	56	South Georgia	134
Effingham	11	Georgia Medical Society	89
Elbert	12	Elbert	92
Emanuel	25	Emanuel	103
Evans	8	Ogeechee River	88
Fannin	7	Blue Ridge	88
Fayette	16	Clayton-Fayette	94
Floyd	27	Floyd-Polk-Chattooga	103
Forsyth	13	Chattahoochee	92
Franklin	28	Franklin-Hart	105
Fulton	29	Medical Assoc. of Atlanta	105
Gilmer	7	Blue Ridge	88
Glascock	54	Richmond	129
Glynn	30	Glynn	121
Gordon	31	Gordon	122
Grady	65	Thomas Area	137
Greene	49	Oconee Valley	129
Gwinnett	13	Chattahoochee	92
Habersham	33	Habersham	122
Hall	34	Hall	123
Hancock	49	Oconee Valley	129
Haralson	10	Carroll-Douglas-Haralson	88
Harris	45	Meriwether-Harris-Talbot	125
Hart	28	Franklin-Hart	105
Heard	68	Troup	138
Henry	59	Spalding	135
Houston	26	Peach Belt	124
Irwin	5	Ben Hill-Irwin	85
Jackson	37	Jackson-Banks	124
Jasper	2	Baldwin	84
Jeff Davis	1	Altamaha	84
Jefferson	39	Jefferson	125
Jenkins	8	Ogeechee River	88
Johnson	42	Laurens	125
Jones	6	Bibb	85
Lamar	59	Spalding	135
Lanier	56	South Georgia	134
Laurens	42	Laurens	125
Lee	23	Dougherty	102
Liberty	62	St. John's Parish	137
Lincoln	78	Wilkes	141
Long	11	Georgia Medical Society	89
Lowndes	56	South Georgia	134
Lumpkin	34	Hall	123
McDuffie	44	McDuffie	125
McIntosh	11	Georgia Medical Society	89
Macon	36	Peach Belt	124
Madison	15	Crawford W. Long	93
Marion	61	Sumter	136
Meriwether	45	Meriwether-Harris-Talbot	125
Miller	58	Southwest Georgia	135
Mitchell	46	Mitchell	126
Monroe	6	Bibb	85
Montgomery	57	Southwest Georgia	135
Morgan	49	Oconee Valley	129
Murray	76	Whitfield-Murray	140
Muscogee	47	Muscogee	126
Newton	48	Newton-Rockdale	128
Oconee	15	Crawford W. Long	93
Oglethorpe	15	Crawford W. Long	93

County	County No.	County Medical Society	Page Number
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Pickens	14	Cherokee-Pickens	92
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Pike	69	Upson	139
Polk	27	Floyd-Polk-Chattooga	103
Pulaski	50	Ocmulgee	129
Putnam	2	Baldwin	84
Quitman	58	Southwest Georgia	135
Rabun	60	Stephens-Rabun	136
Randolph	53	Randolph-Stewart-Terrell	129
Richmond	54	Richmond	129
Rockdale	48	Newton-Rockdale	128
Schley	61	Sumter	136
Screven	55	Screven	134
Seminole	21	Decatur-Seminole	98
Spalding	59	Spalding	135
Stephens	60	Stephens-Rabun	136
Stewart	53	Randolph-Stewart-Terrell	129
Sumter	61	Sumter	136
Talbot	45	Meriwether-Harris-Talbot	125
Taliaferro		No Society	
Tattnall	57	Southeast Georgia	135
Taylor	61	Sumter	136
Telfair	64	Telfair	137
Terrell	53	Randolph-Stewart-Terrell	129
Thomas	65	Thomas Area	137
Tift	66	Tift	138
Toombs	57	Southeast Georgia	135
Towns	33	Habersham	122
Treutlen	57	Southeast Georgia	135
Troup	68	Troup	138
Turner	26	Flint	103
Twiggs	6	Bibb	85
Union	7	Blue Ridge	88
Upson	69	Upson	139
Walker	70	Walker-Catoosa-Dade	139
Walton	71	Walton	139
Ware	72	Ware	140
Warren		No Society	
Washington	74	Washington	140
Wayne	75	Wayne	140
Webster	61	Sumter	136
Wheeler	57	Southeast Georgia	135
White	34	Hall	123
Whitfield	76	Whitfield-Murray	140
Wilcox	50	Ocmulgee	129
Wilkes	78	Wilkes	141
Wilkinson	6	Bibb	85
Worth	79	Worth	141



County Medical Societies


MAG District Societies
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2
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Atlanta
Savannah
Thunderbolt
Columbus
Macon
Albany
Augusta
Rome
Athens
Brunswick
St. Simons Island
Waycross
Valdosta
Thomasville
Bainbridge
Douglas
Moultrie
Tifton
Statesboro
Dublin
Milledgeville
Griffin
Newnan
LaGrange
Carrollton
Cartersville
Dalton
Chatsworth
Ringgold
Summerville
Calhoun
Gainesville
Cumming
Jasper
Canton
Marietta
Decatur
Norcross
Lawrenceville
Monroe
Covington
Conyers
Jonesboro
Fayetteville
Peachtree City
Union City
College Park
East Point
Hapeville
Forest Park
Riverdale
Fairburn
Palmetto
Senoia
Douglasville
Villa Rica
Temple
Bremen
Buchanan
Haralson
Polk
Cedartown
Rockmart
Paulding
Cobb
Fulton
Roswell
Alpharetta
Woodstock
Acworth
Kennesaw
Cherokee
Pickens
Gilmer
Fannin
Union
Towns
Rabun
Habersham
White
Lumpkin
Dawson
Hall
Banks
Franklin
Hart
Stephens
Clarke
Oconee
Oglethorpe
Madison
Elbert
Jackson
Barrow
Walton
Newton
Rockdale
DeKalb
Henry
Clayton
Fayette
Coweta
Heard
Troup
Meriwether
Pike
Lamar
Upson
Spalding
Butts
Jasper
Putnam
Greene
Morgan
Taliaferro
Wilkes
Lincoln
Columbia
McDuffie
Warren
Hancock
Glascock
Jefferson
Burke
Richmond
Screven
Jenkins
Emanuel
Johnson
Washington
Wilkinson
Baldwin
Monroe
Bibb
Crawford
Peach
Houston
Twiggs
Laurens
Treutlen
Candler
Bulloch
Effingham
Evans
Toombs
Montgomery
Tattnall
Bryan
Chatham
Liberty
Long
Jeff Davis
Appling
Wayne
Pierce
Ware
Brantley
Glynn
Camden
Charlton
Clinch
Echols
Lanier
Lowndes
Berrien
Cook
Irwin
Tift
Turner
Worth
Colquitt
Thomas
Brooks
Grady
Decatur
Seminole
Early
Calhoun
Clay
Randolph
Terrell
Lee
Dougherty
Mitchell
Miller
Baker
Quitman
Stewart
Webster
Sumter
Schley
Dooly
Crisp
Wilcox
Pulaski
Dodge
Bleckley
Taylor
Talbot
Harris
Muscogee
Chattahoochee
Marion
Macon
Houston
Peach
Bibb
Jones
Monroe
Lamar
Meriwether
Troup
Coweta
Fayette
Spalding
Butts
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Rockdale
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Walton
Oconee
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Clarke
Madison
Elbert
Franklin
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Stephens
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Banks
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Cherokee
Pickens
Gilmer
Fannin
Union
Towns
Rabun
Chattooga
Floyd
Gordon
Whitfield
Murray
Walker
LaFayette
Catoosa
Dade
Walker
Whitfield
Murray
Gilmer
Fannin
Union
Towns
Rabun
Habersham
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Dawson
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Elbert
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Cherokee
Pickens
Gordon
Chattooga
Floyd
Polk
Haralson
Paulding
Cobb
Fulton
Cherokee
Bartow
Carroll
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Coweta
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Elbert
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Stephens
Habersham
White
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Dawson
Hall
Banks
Jackson
Gwinnett
Forsyth
Cherokee
Pickens
Gilmer
Fannin
Union
Towns
Rabun

Explanation of Roster Information

This roster is made up of physicians whose names were forwarded to the Headquarters Office of the Medical Association of Georgia by the secretaries of the component county medical societies as being members in good standing as of June 1, 1976. Also included in this roster are the names of those physicians who are classified, according to membership status, as: 1) Active; 2) Active, Intern and Resident; 3) Active, Dues Exempt; 4) Associate; 5) Honorary; 6) Retired; and 7) Service. Only members in the first two classifications pay dues. Consult the county society secretary concerning omissions.

This roster contains two types of lists on the membership: the first is alphabetical, and the second is by county medical society. In each the following information is given: name, county medical society number, membership status and specialty on the first line; address on the second line. All city names not followed by a state name are in Georgia. The County Guide List preceding this page lists each county, the number and name of the county medical society of which it is a part, and the page on which that listing begins.

KEY TO LETTER ABBREVIATIONS

TYPES OF MEMBERSHIP

ACT	Active Member
I&R	Active, Intern and Resident
AF	Affiliate Member
A	Associate Member
DE 1	Active Member, Dues Exempt—financial hardship or illness
DE 2	Active Member, Dues Exempt—in postgraduate training
DE 4	Active Member, Dues Exempt—on temporary duty with the armed forces or equivalent
DE 5	Active Member, Dues Exempt—over 70 years of age
H	Honorary Member
R	Retired
S	Service Member
ST	Student Affiliate

SPECIALTIES OF PRACTICE

ACM	Academic Medicine
Ad	Hospital Administration
Al	Allergy
ALR	Otology, Laryngology, Rhinology
AM	Aviation Medicine
Anes	Anesthesiology
Bact	Bacteriology
C	Cardiovascular Disease
CH	College Health
CP	Clinical Pathology
D	Dermatology
E	Epidemiology
EM	Emergency Medicine
En	Endocrinology
FP	Family Practice
G	Gynecology
GE	Gastroenterology
I	Internal Medicine
Ind	Industrial Medicine
N	Neurology
NE	Nephrology
NM	Nuclear Medicine
NR	Neuroradiology
NS	Neurological Surgery
OALR	Ophthalmology, Otology, Laryngology, Rhinology
Ob	Obstetrics
ObG	Obstetrics, Gynecology
OcM	Occupational Medicine
On	Oncology
Oph	Ophthalmology
Or	Orthopedic Surgery
OrS	Oral Surgery
Oto	Otolaryngology
P	Psychiatry
Path	Pathology
Pd	Pediatrics
PdC	Pediatric Cardiology
PdN	Pediatric Neurology
Phar	Pharmacology
PH	Public Health
PL	Plastic Surgery
PM	Physical Medicine
PN	Psychiatry Neurology
Pr	Proctology
Pul	Pulmonary Diseases
R	Roentgenology, Radiology
Su	Surgery
TS	Thoracic Surgery
U	Urology
VS	Vascular Surgery

1976-77 ROSTER

ALPHABETICAL ROSTER

A

ABBOTT,EMILE G. 48 ACT I
2121 FLAT SHOALS RD., CONYERS 30207
ABBOTT,OSLER A. 29 DE1 SU
3037 W. PINE VALLEY RD. NW, ATLANTA 30305
ABELE,DONALD C. 54 ACT D
MED. COLLEGE OF GA., AUGUSTA 30902
ABELLERA,E. Q. 16 ACT SU
5330 WARRINGTON PL., COLLEGE PK 30349
ABEND,MELVIN N. 29 ACT SU
6063 PEACHTREE PKWY., NORCROSS 30071
ABERNATHY,A. H.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
ABERNATHY,ERNEST W. 29 ACT SU
157 N. MAIN ST., JONESBORO 30236
ABNEY,HOWARD T. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
ABOUL-KHAIR,SIDKY 54 ACT I
304 JONES AVE., WAYNESBORO 30830
ABRAMSON, NORMAN 06 ACT R
MEDICAL CENTER OF CENTRAL GA., MACON 31201
ACHECAR,FRED A. 16 ACT NS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
ACKERMAN,ELLIOTT A. 22 ACT OR
365 WINN WAY, DECATUR 30030
ACREE,JOHN W. 34 ACT FP
HIAWASSEE 30546
ACREE,RUSSELL A. 56 ACT FP
HAHIRA 31632
ADAIR,HAROLD E. 29 ACT U
490 PEACHTREE ST. NE, ATLANTA 30308
ADAIR,M. C. 27 ACT FP
FLOYD CO. HOSP., ROME 30161
ADAMS,CHARLES D. 29 ACT D
34 SEVENTH ST., NE, ATLANTA 30308
ADAMS,CHARLES P. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
ADAMS,ELISABETH K. 29 A I
1685 MASON MILL RD NE, ATL. 30329
ADAMS,HANS W. 54 ACT I
380 HOSPITAL DR #460, MACON 31201
ADAMS,J. FRED 36 DE5 FP
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ADAMS,JOHN B,JR. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015
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HUTCHESON MEM. HOSP., FT. OGLETHORPE 30741
ADAMS,MELVIN L. 06 ACT EM
3037 MALVERN HILL DR., MACON 31208
ADAMS,THOMAS M. 36 ACT
MONTEZUMA 31063
ADAMS,WILLIE,JR. 23 ACT OBG
711 N. MONROE ST., ALBANY 31701
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P.O. BOX 33247., DECATUR 30033
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1414 S. MAIN ST., MOULTRIE 31768
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2432 PARKWOOD DRIVE, BRUNSWICK 31520
ADDISON,WINNIFRED A. 34 ACT OBG
1144 VINE ST. NE, GAINESVILLE 30501
ADERHOLT,HEWLETT EDWIN 29 ACT ANES
1968 PEACHTREE RD.,NW, ATLANTA 30309
ADICKES,H. F.,JR. 30 ACT P
5 RETREET PL., ST. SIMONS. ISL. 31522
ADKINS,H. T. 72 A PH
P. O. DRAWER 1110, WAYCROSS 31501
ADKINS,THOMAS E. 70 ACT FP
789 CHICKAMAUGA AVE., ROSSVILLE 30741
AGNOR,E. B. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
AGOSTAS,W. N. 54 ACT I
1021 15TH STREET, AUGUSTA 30901
AGRAZ,RODOLFO R. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
AGRIN,ALFRED 34 A R
315 S. ENOTA DR., GAINESVILLE 30501
AGUERO,OSCAR E. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31601
AGUILAR,AGUSTIN 29 ACT ANES
5662 QUEENSBOROUGH DR. N.E., ATLANTA 30328
AGUILAR,SANTIAGO J. 02 ACT P
914 RIVERBEND DR., MILLEDGEVILLE 31061
AGUIRRE, DENNIS M. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
AHMANN,PETER A. 29 ACT PD
1365 CLIFTON RD. NE, ATLANTA 30322
AHN,YOUNG W. 29 ACT OBG
69 BUTLER ST. SE, ATLANTA 30303
AJOY,ANA B. 29 ACT ANES
114 ESSEX AVE.,N.W., ATLANTA 30339
AKAMATSU,YASUYUKI 54 ACT PATH
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AKIN,JOHN T.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
ALARCON,ALFREDO 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
ALDAY,JAMES M.,JR. 34 ACT OR
650 BROAD ST. SE, GAINESVILLE 30501
ALDEN,HERBERT S. 29 DE5 D
3316 PIEDMONT RD. NE, ATLANTA 30305
ALDERETE,JOSEPH F. 29 S P
77L MCDONOUGH BLVD., SE, ATLANTA 30315
ALDERMAN,EARL L. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
ALDRIDGE,STANLEY P. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
ALEXANDER,G. H. 06 DE5 FP
235 MEDICAL COURT, FORSYTH 31029
ALEXANDER,HAROLD H. 29 ACT OR
6500 VERNON WOODS DR. NE, ATLANTA 30328
ALEXANDER,J. L. 11 ACT SU
40 MEDICAL ARTS CENTER, SAVANNAH 31405
ALEXANDER,JAMES H. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD., ATLANTA 30342
ALFERT,HAROLD J. 16 ACT U
2788 BAYARD ST., #103, EAST POINT 30344
ALFONSO,GABRIEL M. 02 A P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
ALFONSO,JOSE G. 56 ACT PD
310 JANET ST., VALDOSTA 31601
ALFRED,DEWITT C.,JR. 29 ACT P
80 BUTLER ST. SE, ATLANTA 30303
ALISAGO,ANDRES J. JR. 70 ACT ANES
HUTCHESON MEM. HOSP, FT OGLETHORPE 30741
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ALLEN,CALVIN H.,JR. 34 ACT ANES
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ALLEN,E. W.,SR. 02 DE5 P
P.O. BOX 747, MILLEDGEVILLE 31061
ALLEN,EDWIN W.,JR. 02 ACT I
P.O. DRAWER 310, MILLEDGEVILLE 31061
ALLEN,H. D.,JR. 02 DE5 P
MILLEDGEVILLE 31061
ALLEN,H. H. 22 DE5 FP
2343 HENDERSON MILL RD., ATLANTA 30342
ALLEN,JOHN EDWARD,JR. 29 ACT PD
1649 CLEVELAND AVE., EAST POINT 30344
ALLEN,JOHN J. 15 ACT FP
P.O. BOX 6124., ATHENS 30601
ALLEN,LANE H. 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
ALLEN,LAWRENCE LANIER 69 ACT FP
211 THURSTON STREET, THOMASTON 30286
ALLEN,LEE T. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
ALLEN,MARSHALL B.,JR. 54 ACT N
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ALLEN,THOMAS M. 53 ACT FP
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ALMAND,JOSEPH M.,JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240
ALONSO,JORGE P. 59 ACT ANES
604 S. 8TH ST., GRIFFIN 30223
ALONSO,KENNETH B. 16 ACT PATH
2921 MARGARET MITCHELL CT NW, ATLANTA 30327
ALPERIN,HERBERT 29 ACT PD
5675 PTREE:DUNWOODY RD., NE, ATLANTA 30342
ALPERN,ROBERT J. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
ALTHISAR,H. M. 54 ACT FP
VA HOSP., AUGUSTA 30904
ALVAREZ-MENA,SERGIO C. 02 ACT I
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
ALVAREZ,ANGEL C. 47 ACT PD
7121 LULLWATER RD., COLUMBUS 31904
ALVAREZ,H. W. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
ALVAREZ,M. L. 11 ACT PATH
1804 STILLWOOD DR., SAVANNAH 31406
AMATRIAIN,F. F. 22 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
AMBROSE,SAMUEL S.,JR. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
AMERSON,J. RICHARD 29 ACT SU
EMORY UNIVERSITY CLINIC, ATLANTA 30322
AMMONS,JOHN C. 29 S N
1670 CLAIRMONT RD. NE, ATLANTA 30329
AMOS,WILLIAM L,JR 47 ACT OBG
P.O. BO 157, COLUMBUS 31902
ANDERS,MACELYN V. 08 ACT FP
MED. DIR. GA. SOU. COLL., STATESBORO 30458
ANDERS,PATRICK L. 29 ACT OBG
2726 FELTON DRIVE, EAST POINT 30344
ANDERS,REBEKAH Y. 29 ACT FP
2726-A FELTON DR., EAST POINT 30344
ANDERSON,BENJAMIN S. JR. 27 ACT FP
P. O. BOX 508, CEDARTOWN 30125
ANDERSON,GROVER L. 29 ACT NS
4326 HARRIS VALLEY RD. NW, ATL 30342
ANDERSON,JOHN M. 29 ACT P
490 PEACHTREE ST. NE, ATLANTA 30308
ANDERSON,PAUL D. 47 DE4 I
MARTIN ARMY HOSP., FT. BENNING 31905
ANDERSON,ROBERT H.,JR 34 ACT SU
194 GOLD ST., GAINESVILLE 30501
ANDERSON,SAMUEL A. 29 DE5 P
2300 N. VIENNA, RUSTON, LA. 71270
ANDERSON,THOMAS J.,JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
ANDERSON,W. R. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709
ANDERSON,WILLIAM B. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329
ANDRADE,J. ROBIN DE 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
ANDREWS,CHAS. R.,JR. 14 ACT SU
P.O. BOX 308, CANTON 30114
ANDREWS,JAMES R. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901
ANDREWS,RUSSELL E. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161
ANGELL,JOHN H. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
ANSARI,AMIR H. 29 ACT OBG
300 BOULEVARD,NE, ATLANTA 30312
ANTHONY,H.F.,JR. 69 ACT R
P. O. BOX 170, THOMASTON 30286
ANTHONY,JAMES E.,JR. 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
ANTON,BLANCA R. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329
ANTROBUS,LEROY C. 29 ACT PD
495 E. CROSSVILLE RD., ROSWELL 30075
APANAY,MANOLO B. 16 ACT SU
409 ARROWHEAD BLVD., JONESBORO 30236
APGAR,JOHN T. 22 ACT D
13 LAVISTA PER. OFC. PK., TUCKER 30084
APPEL,SIDNEY D. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
APPLE,DAVID F. 29 ACT OR
3200 HOWELL MILL RD., ATLANTA 30327
APPLETON,BROWN G. 11 ACT EM
P.O. BOX 6688, STA. C, SAVANNAH 31405
AQUILAR,JUAN J. 42 S SU
VA CENTER, DUBLIN 31021
ARANEDA-CASTILLO,E. R. 17 ACT PD
1676 MULKEY RD., AUSTELL 30001
ARANGO,VIRGILIO A. 29 ACT PD
35 LINDEN AVE. NE., ATLANTA 30308
ARELLANO,BERNARD G. 23 ACT FP

ARIAS,RAMON A. 17 ACT PD
2404 AUSTELL RD., AUSTELL 30001
ARKIN,MURRAY C. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405
ARMBRUSTER, KENT F.W. 16 ACT I
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
ARMSTRONG,CHARLES L. 29 ACT FP
5675 PTREE DUNWOODY N.E., ATLANTA 30342
ARMSTRONG,EDWARD S. 23 ACT I
223 THIRD AVE., ALBANY 31705
ARMSTRONG,GEORGE F.,JR. 47 ACT PD
THE MEDICAL CENTER, COLUMBUS 31902
ARMSTRONG,NATHANIEL E. 30 ACT SU
P.O. BOX 1258, BRUNSWICK 31520
ARNALL,JOHN ROBERT 36 ACT FP
PERRY 31069
ARNETT,THOMAS E. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
ARNOLD,HARRY D.,JR. 29 ACT OPH
3280 HOWELL MILL RD STE 229, ATLANTA 30327
ARNOLD,J. A. 22 ACT FP
2170 BRIARCLIFF RD. N.E., ATLANTA 30329
ARNOLD,J. H. 20 DE1 FP
P. O. BOX 279, NEWNAN 30263
ARNOLD,M. F. 50 ACT FP
TAYLOR MEMORIAL HOSP., HAWKINSVILLE 31036
ARNOLD,MCALPIN H. 12 ACT FP
46 LAUREL DR., ELBERTON 30635
ARONOVITZ,GERSON H. 22 ACT PD
2714 CLAIRMONT RD. NE, ATLANTA 30329
ARRAS,MILTON J. 30 ACT PATH
P.O. BOX 1518, BRUNSWICK 31520
ARRENDALE,JOE J. 10 ACT FP
8435 PRICE AVE., DOUGLASVILLE 30134
ARRINGTON,JOHN H.,III 54 ACT PATH
PATHOLOGY DEPT, MCG, AUGUSTA 30902
ARRUE,LUIS R. 16 ACT PD
250 ARROWHEAD BLVD., CT. A, JONESBORO 30236
ARTEAGA,OLIVER 29 DE5 OALR
384 PEACHTREE ST. NE, ATLANTA 30308
ARTIME,MANUEL E. 22 ACT AL
1275 MCCONNELL DR., DECATUR 30033
ARWOOD,WILLIAM C.,JR. 46 ACT
PELHAM 31779
ASBELL,JIMMY R. 06 ACT OR
380 HOSPITAL DRIVE, MACON 31201
ASERON,CIRILO,JR. 08 ACT R
BULLOCH COUNTY HOSPITAL, STATESBORO 30458
ASHER,HAROLD 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
ASKEW,JAMES L. 16 ACT R
BOX 21, RIVERDALE 30274
ASKREN,EDWARD L.,III 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
ASKREN,EDWARD L.,JR 29 ACT OPH
1293 PEACHTREE ST. NE., ATLANTA 30309
ASOKAN,SANKARAN K. 54 ACT I
MED COLLEGE OF GA, AUGUSTA 30902
ASTIN,PHIL C.,JR. 10 ACT FP
702 DIXIE STREET, CARROLLTON 30117
ASTON,JAMES K. 61 ACT R
712 FORSYTH ST., AMERICUS 31709
ATHA,JOHN F. 27 ACT FP
HAGUE AVE., ROCKMART 30153
ATHA,WILLIAM J.,JR. 27 ACT
RT. 5, RIVERMONT RD, ROME 30161

ATKINS,EARNEST C. 22 ACT SU
2910 N. DRUID HILLS RD., ATLANTA 30329
ATKINS,MARY T. 17 R PD
173 FOREST DR., SMYRNA 30080
ATKINS,SAM O. 29 ACT U
2600 GORDON ROAD,SW, ATLANTA 30311
ATKINSON,GEORGE O. 29 ACT R
1405 CLIFTON RD.,NE, ATLANTA 30322
ATKINSON,H. C. 06 DE5 I
724 HEMLOCK ST., MACON 31201
ATKINSON,JOHN P. 06 ACT I
724 HEMLOCK ST., MACON 31201
ATKINSON,STEWART 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
ATKINSON,THEODORE E. 06 ACT
724 HEMLOCK STREET, MACON 31201
ATWATER,JOHN S. 29 ACT GE
478 PEACHTREE ST. N.E., ATLANTA 30308
ATWATER,JOHN S.,JR. 29 DE4 I
1920-26TH AVE. NW, ROCHESTER, MINN. 55901
AUSTIN,G. J.,JR. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603
AUSTIN,J. L. 59 ACT OALR
610 S. 8TH ST., GRIFFIN 30223
AUSTIN,WM. F. 30 ACT
3011 KEMBLE, BRUNSWICK 31520
AUSTON,PAUL W. 68 ACT R
W. GA. MEDICAL CENTER, LAGRANGE 30240
AVANT,EARL S. 06 ACT ANES
2923 GENERAL LEE RD., MACON 31204
AVERA,BERTRAM PRICE,JR. 42 S I
VA HOSPITAL, DUBLIN 31021
AVERA,JOHN B. 30 DE1
2560 TARA LA., BRUNSWICK 31520
AVERETT,JAMES E.,JR. 29 ACT OR
35 COLLIER RD. NW, ATLANTA 30309
AVERITT,THOMAS E. 44 ACT FP
P. O. BOX 408, THOMSON 30824
AVERY,ANTHONY P. 27 ACT OTO
26 BALE ST., ROME 30161
AVERY,WILLIAM G. 29 ACT OBG
275 CARPENTER DR. NE, ATLANTA 30328
AVRET,EDWIN T. 22 ACT I
4151 MEMORIAL DR.,105-B, DECATUR 30032
AYCOTH,EDWARD D. 29 ACT R
490 PEACHTREE ST #255-B, ATLANTA 30308
AYER,G. DARRELL,JR. 29 ACT PATH
BOX 12466, ATLANTA 30305
AZAR,GORDON J. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
AZIZ,EZZAT M. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902

B

BACKERMAN,IVAN A. 29 ACT OBG
1311 CLEVELAND AVENUE, EAST POINT 30344
BAGHERI,M.T. 13 ACT TS
14 GWINNETT DR., LAWRENCEVILLE 30245
BAGLEY,CHARLES E. 72 ACT FP
P.O. BOX 220, ALMA 31510
BAILEY,A. GLENN 68 ACT SU
303 SMITH ST., LA GRANGE 30240
BAILEY,HENRY WRIGHT 54 ACT
1500 JOHNS RD., AUGUSTA 30904
BAILEY,JAMES A. 29 ACT PM
2797 CAMPBELLTON RD. SW, ATLANTA 30311
BAILEY,JOSEPH P. 54 ACT I
TALMADGE HOSP., AUGUSTA 30902
BAILEY,M. THOMAS,JR. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BAILEY,T. E. 54 ACT PD
1111 DRUID PARK AVE., AUGUSTA 30904
BAILEY,WILLIAM M. 06 ACT I
618 ORANGE ST., MACON 31201
BAIRD,JOSEPH B.,JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
BAIRD,L. STEPHENS 29 ACT SU
1835 DELOWE DR. S.W., ATLANTA 30311
BAKER,CHARLES R. F.,JR. 29 ACT SU
69 BUTLER ST. SE, ATLANTA 30303
BAKER,J. JAY 29 ACT ON
5675 PEACHTREE DNWDY RD NW, ATLANTA 30342
BAKER,W. R. 50 ACT SU
HAWKINSVILLE 31036
BALBONA,JOSE L. 29 ACT P
3316 PIEDMONT RD. NE, ATLANTA 30305
BALCOS, ORLANDO G. 69 ACT
BOX 128,DRS. CLINIC, ROBERTA 31078
BALDWIN,B. CARTER 47 ACT D
1217 PEACOCK AVE., COLUMBUS 31901
BALL,HORACE C. 22 ACT OBG
231 E. PONCE DE LEON, DECATUR 30030
BALL,TURNER I. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
BALL,WESLEY J. 11 ACT SU
1814 ABERCORN ST., SAVANNAH 31401
BALLARD,MARGUERITE C. 29 ACT I
3092 ARGONNE DR. NW, ATLANTA 30305
BAMFORD,SOPHIA 78 ACT PATH
WASHINGTON 30673
BANCKER,EVERT A.,JR. 29 DE1 I
125 RIVER NORTH DR. NW, ATLANTA 30328
BANKS,RAFE,JR. 34 ACT U
290 ENOTA DR. NE, GAINESVILLE 30501
BANNISTER,JAMES P. 29 ACT P
478 PEACHTREE ST.,NE, ATLANTA 30308
BARDACK,RICHARD A. 17 ACT C
50 PLAZA WAY,NE, MARIETTA 30060
BARFIELD,JAMES E. 57 ACT
300 ARLINGTON DR., VIDALIA 30474
BARFIELD,WILLIAM E. 54 ACT OBG
1445 HARPER ST., AUGUSTA 30902
BARFIELD,WILLIAM E.,JR. 54 A OBG
MED. COLLEGE OF GA., AUGUSTA 30902
BARGERON,EUGENE P. 11 ACT OR
P.O. BOX 6156, SAVANNAH 31405
BARIA,WILLIAM H. 22 ACT I
2895 N. DRUID HILLS RD. NE, ATLANTA 30329
BARKER, CHARLES O. 56 ACT FP
P.O. BOX 2999, VALDOSTA 31601
BARKSDALE,C. R.,JR. 29 ACT FP
44 SMITH ST., FAIRBURN 30213
BARNES,JOHN J. 29 ACT OBG
2045 PEACHTREE RD. NE, ATLANTA 30309
BARNES,JOSEPH H. 29 ACT OBG
5675 P-TREE-DNWDY RD,NE, ATLANTA 30342
BARNES,WADDELL 06 ACT I
800 SPRING ST., MACON 31201
BARNES,WALTER P.,JR. 06 ACT OR
671 HEMLOCK ST., MACON 31201
BARNETT,CRAWFORD F.,JR. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
BARNETT,J. C.,JR. 17 ACT NS
776 CANTON RD., MARIETTA 30060
BARNETT,JOHN E.,JR. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
BARNETT,STEPHEN T.,JR. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
BARNWELL,WILLIAM L. 76 ACT OPH
1217 MEMORIAL DRIVE, DALTON 30720
BARR,ROBERT E. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015
BARRON,WM. E. JR. 20 ACT I
P.O. BOX 609, NEWNAN 30263
BARROSO,CARLOS H. 36 ACT U
507A N. HOUSTON RD #1, WARNER ROBINS 31093
BARROW,BEN C. 15 ACT FP
675 RIVERHILL DR., ATHENS 30601
BARROW,J. GORDON 29 ACT I
938 PEACHTREE ST. NE, ATLANTA 30309
BARTHOLOMEW,PHILIP R. 29 ACT OBG
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
BARTLETT, GLENN H. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
BARTON,DEWEY L. 56 ACT R
DOCTORS BLDG., VALDOSTA 31603
BARTON,EARL G.,JR. 22 ACT PATH
2701 N. DECATUR RD., DECATUR 30030

BARTON,JAMES HOWARD 71 ACT
SOCIAL CIRCLE 30279
BARTON,WILLIAM L. 06 ACT ALR
744 FIRST ST., MACON 31201
BASHINSKI,BENJAMIN,JR. 06 ACT U
839 FIRST STREET, MACON 31201
BASKIN,HENRY J. 68 ACT I
303 SMITH ST., LAGRANGE 30240
BASKIN,J. HAGIN,JR. 29 ACT SU
490 PEACHTREE ST. N. E., ATLANTA 30308
BASS,F. DONALD 20 ACT SU
240 JACKSON ST., NEWNAN 30263
BATCHELOR,CURTIS A. 10 ACT FP
405 ALABAMA ST., BREMEN 30110
BATEMAN,J. DAN 23 ACT SU
410-12 FOURTH AVE., ALBANY 31705
BATEMAN,NEEDHAM B. 29 ACT SU
401 PEACHTREE ST. NE, ATLANTA 30308
BATES,JACK M. 34 ACT P
500 SPRING ST. NW, GAINESVILLE 30501
BATES,JOHN G. 53 ACT FP
201 RANDOLPH ST., CUTHBERT 31740
BATES,ROGER A. 72 ACT SU
410 ZACHRY ST., WAYCROSS 31501
BATES,W. B.,JR. 72 ACT FP
WAYCROSS 31501
BATH,NICHOLAS M. 22 ACT U
755 COLUMBIA DR.,STE. B, DECATUR 30030
BATTEY,L. L. 54 ACT I
1021 15TH STREET, AUGUSTA 30901
BATTLE,LEE H.,JR. 27 ACT SU
321 W 7TH STREET, ROME 30163
BATTS,A. S. 50 ACT
HAWKINSVILLE 31036
BAUGH,JAMES E. 02 ACT FP
811 N. COBB, MILLEDGEVILLE 31061
BAUGH,WILBUR E. 02 ACT R
P. O. BOX 926, MILLEDGEVILLE 31062
BAUMGARTNER,BRUCE R. 29 ACT R
1365 CLIFTON RD,NE, ATLANTA 30322
BAUTISTA,GRACE C. 62 ACT PD
P.O. BOX 406 FRASER DR., HINESVILLE 31313
BAUTISTA,VICTOR C. 62 ACT ANES
LIBERTY MEMORIAL HOSP., HINESVILLE 31313
BAXLEY,WILLIAM W.,JR. 06 ACT OTO
380 HOSPITAL DR., MACON 31201
BAYNE,LOUI G. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BAZEMORE,J. MALCOLM 54 ACT D
1467 HARPER ST., AUGUSTA 30902
BEACH,BESSIE MAE 47 S PD
17 BALENTINE DR., GREENVILLE, S. C. 29605
BEACH,WILLIAM R.,III 29 ACT PATH
2550 WINDY HILL RD,STE 201, MARIETTA 30062
BEALL,AVERY P. 56 ACT FP
P. O. BOX 129, ADEL 31620
BEALL,JAMES H. 15 ACT P
700 OGLETHORPE AVE., ATHENS 30601
BEARD,CARL L. 36 ACT OBG
105 BRIARCLIFF, WARNER ROBINS 31093
BEARD,DONALD E. 29 DE1 U
400 LOG CABIN DR., SMYRNA 30080
BEASLEY,CARROLL 17 ACT
50 PLAZA WAY, MARIETTA 30060
BEASLEY,ERNEST W.,JR. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BECERRA,HERNAN 29 ACT FP
2741 BAYARD ST., EAST PT. 30344
BECHTEL,H. BERNARD 56 ACT D
2101 N. PATTERSON ST., VALDOSTA 31603
BECTON,JAMES L. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904
BEDINGFIELD,JAMES ANDREW 01 ACT
BAXLEY 31513
BEDINGFIELD,W. H. 57 ACT FP
P. O. BOX 629, VIDALIA 30474
BEDINGFIELD,W. O. 11 DE5
3025 BULL ST., SAVANNAH 31405
BEDINGFIELD,W. R.,JR. 54 ACT I
503 GEORGIA AVENUE, N.AUGUSTA,SC 29841

BEECHAM,PAUL E. 17 ACT P
11457 HACKETT RD., ROSWELL 30075
BEESON,CHARLES W.,II 11 ACT C
803 E. 70TH ST., #103, SAVANNAH 31405
BELCHER,WILLIAM T.,JR. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30033
BELFLOWER,ESTOL R. 23 ACT R
P.O. BOX 1924, ALBANY 31702
BELK,BEVERLY 54 ACT PD
P.O. BOX 28, AUGUSTA 30903
BELL,EUGENE D. 18 ACT
DOUGLAS 31533
BELL,FRANK C. 29 ACT OPH
1365 CLIFTON RD.,NE, ATLANTA 30322
BELL,FRED M.,JR. 29 ACT SU
6640 BARTON RD., MORROW 30260
BELL,HUGH V.,JR. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344
BELL,J. A.,JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021
BELL,J. E. 54 ACT PD
1411 GWINNETT ST., AUGUSTA 30902
BELL,RUDOLPH 65 DE5 U
P.O. BOX 1675, THOMASVILLE 31792
BELL,SIDNEY A. 27 ACT OR
HARBIN CLINIC, ROME 30161
BELLVILLE,CHAS. GEORGE 21 ACT SU
BAINBRIDGE 31717
BENNETT,J. W. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902
BENNETT,ROBERT L. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830
BENNETT,V. H. 45 DE5 FP
801 RIVERHILL DR., ATHENS 30601
BENNETT,VAN B. 56 ACT I
RT. 1, BOX 2, VALDOSTA 31601
BENNETT,W. FRED,JR. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30327
BENNETT,WM. H. 29 R U
829 W. WESLEY RD. NW, ATL. 30327
BENSON,EARL B. 17 ACT ANES
254 CHEROKEE STREET, MARIETTA 30061
BENSON,RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533
BENSON,W. H.,JR. 17 ACT I
3188 ATLANTA ST.,S E, SMYRNA 30080
BENTLEY,ALONZO J. 65 ACT OALR
918 S. BROAD ST., THOMASVILLE 31792
BERENS,SANFORD V. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405
BERENSON,MORTON P. 47 ACT I
2748 SUE MACK DR., COLUMBUS 31906
BERG,EDWARD W. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902
BERG,JOSEPH L. 23 ACT OPH
P. O. BOX 483, ALBANY 31702
BERGER,ISRAEL REUBEN 15 ACT R
1010 PRINCE AVENUE, ATHENS 30601
BERGER,MERTON B. 29 ACT P
5600 ROSWELL RD. NE, ATLANTA 30342
BERGHERM,BRUCE A. 29 ACT ANES
1968 PEACHTREE RD. NW, ATLANTA 30309
BERLIN,MELVIN 11 ACT
1 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
BERMAN,DAVE 47 ACT D
1315 4TH AVE., COLUMBUS 31901
BERMAN,JEROME D. 29 ACT PD
6500 VERNON WOODS RD. NE, ATLANTA 30328
BERMAN,MERRILL 17 ACT R
1676 MULKEY RD,SW, AUSTELL 30001
BERN,GERHARD O. 29 S I
275-5TH ST. NW, ATLANTA 30332
BERNSTEIN,JEFFREY A. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
BERRY,ARTHUR N. 47 R OBG
1730 SANDY CIRCLE,112, CAPE CORAL,FLA 33904
BERRY,C. MARKHAM 29 DE2 FP
4665 MYSTIC DR. NE, ATLANTA 30342
BERRY,JOSEPH N. 29 ACT I
6500 VERNON WOODS DR. NE, ATL. 30328

BERRY,MAXWELL R.,JR. 29 ACT GE
3250 HOWELL MILL RD.,NW, ATLANTA 30327
BERRY,ROBERT L. 10 ACT FP
VILLA RICA 30180
BETHEA,JAMES S.,III 17 ACT OR
1664 W. WESLEY RD., ATLANTA 30327
BETHENCOURT,ANTHONY V. 06 ACT I
MED CTR CENTRAL GA, BOX 6000, MACON 31208
BICKERS,DONALD 29 ACT NS
3250 HOWELL MILL RD. NE, ATLANTA 30327
BICKERSTAFF,HUGH J. 47 DE5 OBG
MEDICAL ARTS BLDG., COLUMBUS 31901
BICKERSTAFF,JAMES W.,JR 72 ACT OR
1921 ALICE ST., WAYCROSS 31501
BIENERT,HENRY J. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
BIGGER,JOHN F.,JR. 54 ACT OPH
905-15TH ST.,STE E, AUGUSTA 30901
BIGGERS,WILLIAM H. 29 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
BILLINGHURST,GEORGE A. 54 DE1 FP
P.O. BOX 2354, STUART, FLA. 33494
BILLINGS,CHARLES R. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
BILLINGS,J. E. 31 DE1 FP
CALHOUN 30701
BILLIPS,WILLIAM C. 22 ACT OPH
3576-D CHAMBLEE-TUCKER RD., ATLANTA 30341
BILSTEN,GEORGE G. B. 29 ACT N
35 COLLIER RD. NW, ATLANTA 30309
BIRCH,HERBERT W. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
BIRDSONG,WM. R. 06 ACT PD
531 NORTH AVE., MACON 31201
BISHOP,JOSEPH A. 31 ACT FP
103 S. RIVER ST., CALHOUN 30701
BISHOP,LINTON H.,JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
BISNO,DAVID C. 16 ACT OPH
114 CLAYTON PROF. BLDG, RIVERDALE 30274
BITTLE,CHARLES R. 54 ACT ANES
812 13TH ST., AUGUSTA 30901
BIVENS,EDWARD S. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BIVINGS,F. LEE 29 DE5 PD
3110 HABERSHAM RD. NW, ATLANTA 30305
BIVINS,BLAKE S. 50 ACT FP
BEECH ST., COCHRAN 31014
BLACK,CLYDE E. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
BLACK,GRADY E. 59 ACT PD
567 S. 9TH ST., GRIFFIN 30223
BLACK,JUDSON G. 29 ACT I
3250 HOWELL MILL RD.,NW,305, ATLANTA 30327
BLACK,PAUL W. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BLACK,WILEY S. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
BLACKBURN,J. D. 69 DE5 OR
711 HILL ST.,PO BOX 552, THOMASTON 30286
BLACKMAN,WILLIAM M. 76 ACT OPH
1217 MEMORIAL DR., DALTON 30720
BLACKSHEAR,JOSEPH R. 23 ACT EM

BLACKSHEAR,STUART G. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
BLACKSTON,RONALD D. 22 ACT PD
1365 CLIFTON RD. NE, ATLANTA 30322
BLAINE,B. C. 29 ACT I
2034 MAIN STREET NW, ATLANTA 30318
BLAIR,H. DUANE 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
BLALOCK,H. SHERMAN 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
BLALOCK,JACK H.,JR. 47 ACT I
MEDICAL ARTS BLDG., COLUMBUS 31901
BLALOCK,JOHN C. 29 DE5 SU
734 W. WESLEY RD. NW, ATLANTA 30327
BLALOCK,TULLY T. 29 ACT I
3280 HOWELL MILL RD,NW,217, ATLANTA 30327
BLANC,JAMES S. 29 ACT SU
1678 MULKEY RD., AUSTELL 30001
BLANCHARD,HUBERT H. 59 ACT P
720 HOLMES ST., BARNESVILLE 30204
BLANCHARD,MERCER 47 DE5 PD
940 BLANFORD AVE., COLUMBUS 31906
BLANCHARD,MERCER C. 47 ACT PD
713 20TH ST., COLUMBUS 31904
BLANCHARD,THOMAS W. 54 ACT U
1502 ANTHONY RD., AUGUSTA 30904
BLANCHARD,WILLIAM 27 ACT SU
CEDARTOWN 30125
BLAND,JAMES W.,JR. 29 ACT ANES
1364 CLIFTON RD. NE, ATLANTA 30322
BLANK,SAMUEL 29 S
1670 CLAIRMONT RD NE, DECATUR 30033
BLASINGAME,JOHN T.,JR. 29 ACT SU
75 PIEDMONT AVE., NE, ATLANTA 30303
BLEICH,ALLAN C. 29 ACT I
5675 PTREE-DNWDY RD. NE, ATLANTA 30342
BLEICH,J. K. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
BLISSIT,JOSEPH A. 59 ACT I
169 DECATUR ROAD, MCDONOUGH 30253
BLITCH,PIERCE G.,JR. 54 ACT I
1505 WINTER ST., AUGUSTA 30904
BLIVEN,FLOYD E.,JR. 54 ACT OR
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
BLOCK,DONALD L. 29 ACT OBG
100 COLONY SQ., #1601, ATLANTA 30309
BLOODWORTH,AUGUSTUS F. 34 ACT I
1098 S. ENOTA NE, GAINESVILLE 30501
BLOODWORTH,H. T. 06 ACT ANES
781 SPRING ST., MACON 31201
BLOODWORTH,RONALD C. 17 ACT P
3188 ATLANTA ST. SE, SMYRNA 30080
BLOOM,WALTER L. 17 ACT
225 NORTH AVE. NW, ATLANTA 30313
BLOOM,WILLIAM F. 06 ACT R
777 HEMLOCK ST., MACON 31204
BLUE,JACOB S. 36 S IND

BLUMBERG,MAX M. 29 ACT I
33 PONCE DE LEON AVE. NE, ATLANTA 30308
BLUMBERG,RICHARD W. 29 ACT PD
69 BUTLER ST. S. E., ATLANTA 30303
BLUMENTHAL,IRVIN 29 ACT SU
384 PEACHTREE ST. N. E., ATLANTA 30308
BLUMENTHAL,JEROME B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060
BOATWRIGHT,MARTHA H. 29 ACT P
1970 CLIFF VALLEY WAY NE., ATLANTA 30329
BOBO,W. EARL 22 ACT SU
365 WINN WAY, DECATUR 30030
BOBON,BENIGNO L. 26 ACT PATH
525 CEDAR CREEK DR., ATHENS 30601
BODDIE,A. M. 02 ACT FP
240 N. WAYNE ST., MILLEDGEVILLE 31061
BODDY,A. EVAN 14 ACT
WOODSTOCK 30188
BODZINER,L. S. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
BOGER,RICHARD E. 29 ACT PD
5675 PTREE-DUNWOODY RD, #502, ATLANTA 30342
BOGGESS,NEIL D.,JR. 76 ACT FP
1012 BURLEYSON DR., DALTON 30720
BOHANAN,G. WAYNE 36 ACT R
HOUSTON CO. HOSP., WARNER ROBINS 31093
BOHLER,CHARLES EMORY 08 ACT FP
BOX 8, BROOKLET 30415
BOHLER,CLORINDA S. 54 ACT EM
2279 WRIGHTSBORO RD., AUGUSTA 30904
BOHORFOUSH,J. G. 02 ACT I
MILLEDGEVILLE 31061
BOLEN, RICHARD A. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
BOLTON,RICHARD S. 23 ACT PH

BONAU,ROGELIO 48 ACT SU
5303 ADAMS ST., COVINGTON 30209

BONDURANT,WILLIAM 29 ACT OR
478 PEACHTREE ST. NE, ATLANTA 30308
BONNER,JOHN T. 29 ACT ANES
69 BUTLER ST. SE, ATLANTA 30303
BONNER,WILLIAM H. 15 ACT PD
740 PRINCE AVE., ATHENS 30601
BOOTH,ARTHUR S. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BOOTLE,WM. A.,JR. 06 ACT R
2056 VINEVILLE AVE., MACON 31201
BOOZER,ALBERT MARION 76 ACT FP
DALTON MEM. ARTS BLDG., DALTON 30720
BORDERS,JUEL PATE 29 ACT OBG
375 AUBURN AVE. SE, ATLANTA 30312
BORDON,JOSE ANTONIO 29 ACT ANES
159 FOREST AVE. NE, ATLANTA 30303
BOSS,JAMES L. 10 ACT FP
VILLA RICA 30180
BOSTWICK,JOHN,III 29 ACT PL
25 PRESCOTT ST. NE, ATLANTA 30308
BOSWELL,T. C. 14 ACT FP
TATE 30177
BOSWELL,W. C. 65 DE5 PD
P.O. BOX 1378, THOMASVILLE 31792
BOSWORTH,E. L. 27 ACT I
HARBIN CLINIC, ROME 30161
BOTNICK,ROBERT S. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904
BOTTOMS,WM. R. 13 ACT FP
601 US HWY 19N, CUMMING 30130
BOTTOMY,JOHN R. 29 ACT OBG
2794 WOODLAND PARK DR.,NE, ATL. 30329
BOUSQUET,FRANKLYN P.,JR 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31402
BOWCOCK,JAMES Z. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
BOWDEN,RALPH O. 11 ACT
22 E. TAYLOR ST., SAVANNAH 31401
BOWDEN,TALMADGE A.,JR. 54 ACT SU
MED. COLLEGE OF GA., AUGUSTA 30902
BOWEN,EDWARD G. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BOWEN,J. B. 54 ACT SU
842 GREENE ST., AUGUSTA 30902
BOWEN,JOHN L. 54 DE2 PD
P. O. BOX 1637, ORANGEBURG, S. C. 29115
BOWEN,ROBERT W. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236
BOWEN,WILLIAM L.,JR. 15 ACT OBG
1010 PRINCE AVE., ATHENS 30601
BOWER,THOMAS L. R. 17 ACT ANES
705 JUNIPER ST. NE, ATLANTA 30308
BOWERS,ROBERT E. 76 DE2 FP
721 GLENWOOD DR., CHATTANOOGA, TENN. 37404
BOWLES,F. NORMAN,JR. 17 ACT PATH
3950 AUSTELL RD., AUSTELL 30001
BOWLES,LESTER L. 54 ACT P
P. O. BOX 4687, MARTINEZ 30907
BOWMAN,M. B. 23 ACT SU
1104 N. MONROE ST., ALBANY 31705
BOWYER,FRANK P. 66 ACT PD
418 N. PARK AVE., TIFTON 31794
BOYD,AUGUSTUS B. 15 ACT ANES
P. O. BOX 1732, ATHENS 30601
BOYD,CLAUD A.,JR. 54 ACT D
1509 ANTHONY RD., AUGUSTA 30904
BOYD,DONALD L. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701
BOYD,RONALD J. 02 ACT FP
750 N. COBB ST., MILLEDGEVILLE 31061
BOYD,WM. S. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904
BOYETT,JAMES E. 29 ACT TS
P. O. BOX 429, EAST POINT 30344
BOYETTE,DAVID M. 23 ACT OTO
804 FOURTEENTH AVE., ALBANY 31705
BOYTER,HENRY H. 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901
BRACKETT,J. GORDON 29 ACT ALR
340 BOULEVARD NE, ATLANTA 30312
BRACKETT,MORRIS E. 29 A
47 TRINITY AVENUE SW, ATLANTA 30303
BRACKNEY,EDWIN L. 54 ACT SU
BOX 521 V.A. HOSPITAL, TUSKEGEE, ALA 36083
BRADBURY,ROBERT G. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
BRADDOCK HENRY A. 29 ACT FP
1862 PRINCETON AVE., COLLEGE PARK 30337
BRADLEY,CHARLES K. 34 ACT OPH
1128 VINE ST., GAINESVILLE 30501
BRADLEY,PAUL L. 76 ACT SU
P.O. 1969, DALTON 30720
BRADLEY,R. H. 76 DE5
CHATSWORTH 30705
BRALY,SAMUEL U. 17 ACT FP
DALLAS 30132
BRAMBLETT,A. W.,JR. 06 ACT FP
99 COUNTRY CLUB DR., FORSYTH 31029
BRAMBLETT,RUPERT H. 13 ACT FP
326 DAHLONEGA RD., CUMMING 30130
BRANAN,WM. J.,JR. 22 ACT PD
1989 N. WILLIAMSBURG DR., DECATUR 30033
BRANCH,DAVID L.,JR. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31603
BRAND,ROBERT L. 54 ACT OR
1132 DRUID PARK AVE., AUGUSTA 30904
BRANDON,R. V. 59 DE1 FP
WESTBURY MED CARE HOME, JENKINSBURG 30234
BRANDT,HENRY A. 11 ACT PN
220 EAST HALL STREET, SAVANNAH 31401
BRANNEN,EDMUND A. 06 ACT OBG
675 NEW STREET, MACON 31201
BRANNEN,J. H. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31603
BRANNEN,JAMES O. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033
BRANNON,EMMETT S. 27 ACT I
MCCALL HOSPITAL, ROME 30162
BRANNON,LAWRENCE T. 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BRANSOME,EDWIN D.,JR. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
BRANTLEY,J. G. 42 DE5 FP
WRIGHTSVILLE 31096
BRANTLEY,JAMES W. 75 ACT SU
P.O. BOX 1133, JESUP 31545
BRANTLEY,MARVIN A. 29 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
BRANTLY,EDMUND B. 29 ACT R
20 LINDEN AVE. NE, ATLANTA 30308
BRANYON,DONALD L.,JR. 15 ACT OBG
1010 PRINCE AVE., ATHENS 30601
BRASWELL,L. RENDER 29 R FP
143 W. PACE FERRY RD. NW, ATLANTA 30305
BRAWNER,D. L. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
BRAWNER,JAMES N.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
BRECKENRIDGE,H. E.,JR. 21 ACT FP
HOSPITAL CIRCLE, DONALSONVILLE 31745
BREGMAN,LARRY 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., ATLANTA 30341
BREIBART,SIDNEY 22 ACT PD
11 LAVISTA PER. OFC. PK., TUCKER 30084
BRENNAN,CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
BREWER,JOHN M.,JR. 29 ACT D
384 PEACHTREE ST., NE, ATLANTA 30308
BREWER,PHILIP L. 47 ACT TS
MEDICAL ARTS BLDG., COLUMBUS 31901
BREWER,SPENCER S.,JR. 29 ACT I
1938 PEACHTREE RD. NW, ATLANTA 30309
BREWTON,SAMUEL A. JR. 69 ACT U
612 W. GORDON RD., THOMASTON 30286
BRIANT,THOMAS P. 06 ACT ANES
2121 VIKING CIRCLE, BIRMINGHAM,ALA. 35216
BRICE,ANTON,JR. 22 ACT I
542 CHURCH ST., DECATUR 30030
BRICE,BOYCE S. 27 ACT SU
THE HARBIN CLINIC, ROME 30161

BRIDGER,CLARENCE E. 23 ACT PATH
P.O. BOX 1828, ALBANY 31702
BRIDGES,GLENN J. 29 ACT U
573 W. PEACHTREE ST.,NE, ATLANTA 30308
BRIDGES,H. BENTON 54 ACT OR
1413 GWINNETT ST., AUGUSTA 30902
BRIDGES,MERCER T. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
BRIDGES,W. L.,JR. 66 ACT PD
714 E. 18TH, TIFTON 31794
BRIDGES,WILLIAM H. 23 ACT R
P. O. BOX 1828, ALBANY 31702
BRIDGES,WILLIAM Z. 65 ACT OPH
808 GORDON AVE., THOMASVILLE 31792
BRIGGS,WILLIAM J,III 50 ACT FP
MILAN 31060
BRIGHTWELL,LARRY E. 47 ACT SU
105 DOCTORS BLDG., COLUMBUS 31901
BRILL,HARRY H.,JR. 47 ACT I
1905 SEVENTH AVE., COLUMBUS 31901
BRINKLEY,AVERY B. 06 ACT R
312 CANDLER DR., MACON 31204
BRINSFIELD,DOROTHY 29 ACT PD
2236 SPRING CREEK RD., DECATUR 30033
BRINSON,JOHN B.,JR. 65 ACT FP
808 GORDON AVE., THOMASVILLE 31792
BRISCO,C. D. 71 DE5 I
MONROE 30655
BRITT,C. S. 30 DE5 FP
P.O. BOX 1078, ST. SIMOMS ISL. 31522
BROCATO,SIMONE 47 ACT C
PHYSICIANS BLDG., COLUMBUS 31901
BROCK,ROY CRAWFORD 27 ACT SU
14 PROFESSIONAL COURT, ROME 30161
BRODERICK,JOHN R. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
BRONSTEIN,EDWIN S. 54 ACT OBG
MED. COLLEGE OF GA., AUGUSTA 30902
BROOKS, JAMES C. 68 ACT I
P.O. BOX 490127, ATLANTA 30349
BROOKS,BETTY ANN 22 ACT OBG
365 WINN WAY, DECATUR 30030
BROOKS,CHARLES P. 50 ACT FP
P.O. BOX 35, COCHRAN 31014
BROOKS,COURTNEY C. 22 ACT FP
2223 CANDLER ROAD, DECATUR 30032
BROOKS,W. SCOTT,JR. 29 ACT I
1365 CLIFTON RD NE, ATLANTA 30322
BROOME,HARRY L. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30328
BROWN, NYDA W. 29 ACT P
5075 GREEN PINE DR.,NE, ATLANTA 30342
BROWN,ALAN P. 11 ACT EM
P. O. BOX 13312, SAVANNAH 31406
BROWN,ALGIE C. 29 ACT D
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BROWN,ALLEN N. 54 ACT FP
1439 DRUID PK. AVE, #F, AUGUSTA 30904
BROWN,BOBBY C. 29 ACT PATH
1968 PEACHTREE RD.,NW, ATLANTA 30309
BROWN,CHARLES E. 29 ACT I
21 EIGHTH ST. N. E., ATLANTA 30309
BROWN,CHARLES T. 11 DE5 PH
BOX 7, GUYTON 31312
BROWN,CHARLES W. 29 ACT OR
478 PEACHTREE ST. NE, ATLANTA 30308
BROWN,COLEMAN M. 29 ACT P
1938 PTREE RD. NW., ATLANTA 30309
BROWN,DEMPSEY S. 06 ACT SU
740 HEMLOCK ST., MACON 31201
BROWN,DWIGHT J.,JR. 30 ACT OBG
3020 SHRINE RD., BRUNSWICK 31520
BROWN,EDWARD B. 72 ACT OBG
P. O. BOX 177, WAYCROSS 31501
BROWN,ELBERT H. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093
BROWN,GEORGE W. 59 ACT R
686 S. 8TH STREET, GRIFFIN 30223
BROWN,GROVER J. 04 ACT FP
P. O. BOX 338, LINDALE 30147

BROWN,H. EUGENE 29 DE1 I
622 PARK LN., DECATUR 30033
BROWN,HOWARD S. 29 ACT TS
6500 VERNON WOODS DR. NE, ATLANTA 30328
BROWN,JAMES A. 54 ACT OPH
3651 WHEELER RD, SUITE 100, AUGUSTA 30904
BROWN,JIMMY S. 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305
BROWN,JOSEPH CHRISTOPHER 48 ACT FP
CONYERS 30207
BROWN,JOSEPH E. 30 ACT OR
3104 SHRINE RD., BRUNSWICK 31520
BROWN,LEONARD 17 ACT D
1416 CHEROKEE STREET, MARIETTA 30062
BROWN,LESTER A. 29 ACT ALR
490 PEACHTREE ST. N. E., ATLANTA 30308
BROWN,LUTHER E. 06 ACT OPH
800 FIRST ST., MACON 31201
BROWN,MARK 54 ACT R
TALMADGE MEMORIAL HOSP., AUGUSTA 30902
BROWN,NELSON H. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
BROWN,NYDA W. 29 ACT P
5075 GREEN PINE DRIVE, NE, ATLANTA 30342
BROWN,R. G. 25 DE1 FP
SWAINSBORO 30401
BROWN,ROBERT G. 29 ACT PL
1365 CLIFTON RD.,NE, ATLANTA 30322
BROWN,ROBERT H. 29 ACT ALR
3280 HOWELL MILL RD. NW, ATLANTA 30327
BROWN,ROBERT L. 29 ACT SU
1645 TULLY CIR, STE 126, ATLANTA 30329
BROWN,ROLAND A. 06 R OBG
306 ORANGE ST., MACON 31201
BROWN,S. ROSS 29 DE1 ANES

BROWN,SOLOMON K. 54 ACT R
1467 HARPER STREET, AUGUSTA 30904
BROWN,STEPHEN W. 54 ACT R
1467 HARPER ST., AUGUSTA 30904
BROWN,STEWART D.,JR. 28 ACT FP
200 FRANKLIN SPRINGS ST., ROYSTON 30662
BROWN,THOMAS D.,JR. 34 ACT OTO
304 ENOTA DR., GAINESVILLE 30501
BROWN,W. MORRIS,JR. 06 ACT SU
380 HOSPITAL DR C-430, MACON 31201
BROWN,WALTER J.,JR. 15 ACT I
UNIV HEALTH SERVICE, ATHENS 30602
BROWNE,RODNEY M. 06 ACT OBG
380 HOSP. DRIVE, MACON 31201
BROWNE,THOMAS MORGAN 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
BROWNSBERGER,JOHN F. 56 DE5 SU
LAKELAND 31635
BRUCE,DOUGLAS A. 30 ACT PD
520 OCEAN BLVD., ST. SIMONS IS. 31522
BRUCKNER,HOWARD L. 54 ACT OPH
905 15TH ST., AUGUSTA 30902
BRUNER,BARBARA 29 A PD
69 BUTLER ST. SE, ATLANTA 30303
BRUNS,WM. L.,JR. 54 ACT OBG
1430 HARPER ST., AUGUSTA 30902
BRUNT,GWYNNE T.,JR. 29 ACT R
3312 PIEDMONT RD. NE, ATLANTA 30305
BRYANS,C. I.,JR. 54 ACT OBG
TALMADGE HOSP., AUGUSTA 30902
BRYANT,JAMES M.,JR. 20 ACT
NEWNAN 30263
BRYANT,MILTON F.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
BUCHANAN,L. C. 22 ACT SU
374 W. PONCE DE LEON AVE., DECATUR 30030
BUCKHAULTS,W. W. 11 ACT OPH
905 ABERCORN STREET, SAVANNAH 31401
BUCKNER,LESLIE MARVIN 23 DE5 FP
ROUTE 2, BOX 446, LEESBURG 31763
BUELVAS,RAUL S. 11 ACT SU
11706 MERCY BLVD., SAVANNAH 31406
BUNNEN,ROBERT L. 29 A SU
3312 PIEDMONT ROAD, NE, ATLANTA 30305

BUNYASARANAND,PRICHA 59 ACT D
610 S. 8TH ST., GRIFFIN 30223
BURDISON,WM. R. 54 S
2410 WILLIAMS ST., AUGUSTA 30904
BURGAMY,CLYDE A. 54 ACT OBG
DR. HOSPITAL PLAZA, AUGUSTA 30904
BURGE,DAN 29 ACT I
315 BOULEVARD N.E., ATLANTA 30312
BURGER,CHARLES W. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
BURGSTINER,CARSON B. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
BURK,BILLY D. 47 A OBG

BURLEIGH,BRUCE D. 17 ACT FP
37 MOORE AVE.,NE, MARIETTA 30062
BURNETT,STACY W. 22 ACT PD
2100 PARKLAKE DR. NE, ATLANTA 30345
BURNHAM,JAMES W.,JR. 06 ACT FP
1923 JEFFERSONVILLE RD., MACON 31201
BURNS,D. L. 56 DE5 FP
BOX 3075 CASTLE PK STA, VALDOSTA 31601
BURNS,JAMES B. 17 ACT R
737 CHURCH ST., MARIETTA 30061
BURNS,JAMES R.,JR. 34 ACT FP
700 S. ENOTA DR. NE, GAINESVILLE 30501
BURNS,JOHN KNOX,III 34 ACT OBG
1100 VINE STREET, GAINESVILLE 30501
BURNS,MATTHEW L. 20 ACT SU
15 CAVENDER ST., NEWNAN 30263
BURNS,R. A. 07 ACT FP
BLUE RIDGE 30513
BURNS,WILLIAM B.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
BURR,MAX E. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31902
BURRELL,ZEB,JR. 15 ACT I
ATHENS GENERAL HOSP., ATHENS 30601
BURSON,E. NAPIER,JR. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BURTON,CHARLES G. 06 ACT SU
740 HEMLOCK ST., MACON 31201
BURTON,HERBERT W. 29 DE1 I
25 PRESCOTT ST.,NE, ATLANTA 30308
BUSBEE,PERRY G. 26 ACT FP
CORDELE 31015
BUSEY,T. J. 16 DE5 FP
FAYETTEVILLE 30214
BUSEY,THOMAS J.,JR. 29 ACT U
2748-B FELTON DR., EAST POINT 30344
BUSH,CHARLES K. 29 R P
4425 HARRIS TRAIL, N.W., ATLANTA 30327
BUSH,JAMES L. 42 S OALR
RT. 3,BOX 212A, DUBLIN 31021
BUSH,JOHN 47 DE5 FP
P. O. BOX 141, COLUMBUS 31902
BUSH,LEON H. 23 ACT I
1009 N. MONROE, ALBANY 31701
BUSH,O. B. 29 DE5 FP
57 RUMSON WAY NE, ATLANTA 30305
BUSSEY,J. G. 17 ACT SU
AUSTELL 30001
BUSSEY,JOSEPH G.,JR. 17 ACT SU
5990 LOVE ST., AUSTELL 30001
BUTLER,CHARLES W.,JR. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BUTLER,CLARENCE 47 ACT I
P. O. BOX 4199, COLUMBUS 31904
BUTLER,RICHARD H. 29 S
P. O. BOX 20636, ATLANTA 30320
BUTLER,THOMAS W. 54 ST

BUTLER,WALTER H. 29 ACT ANES
1110 VERNON SPGS. CT. NW, ATLANTA 30327
BUTTERWORTH,HENRY H. 22 ACT I
603 CHURCH STREET, DECATUR 30030
BUTTS,JAMES A. 34 ACT I
1732 VALLEY RD. NE, GAINESVILLE 30501
BUXTON,HUBERT,JR. 06 ACT ANES
4928 GUERRY DR., MACON 31204
BYARS,STEVENS 68 ACT PH
406 COUNTRY CLUB RD., LAGRANGE 30240
BYNE,J. M.,JR. 09 DE5 I
LIBERTY ST., WAYNESBORO 30830
BYRD,M. DANIEL 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BYRNES,WILLIAM F. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344

C

CABANISS,C. DANIEL 47 ACT I
P.O. BOX 951, COLUMBUS 31902
CABANISS,W. HARVEY,JR. 15 ACT D
1010 PRINCE AVENUE, ATHENS 30601
CABEZAS, RODRIGO 29 ACT TS
4555 N. SHALLOWFORD RD., ATLANTA 30341
CABRERA-CICERO,ORLANDO 42 S SU
VA CENTER, DUBLIN 31021
CABRERA-MENDEZ,FABIO 29 DE2 P
80 BUTLER ST. SE, ATLANTA 30303
CACCHIOLI,LOUIS G. 28 ACT FP
202 W. HOWELL ST., HARTWELL 30643
CADIER,THOMAS R. 29 A
5095 PINE BARK CIRCLE, DUNWOODY 30338
CAIN,ROBERT T. 65 ACT FP
P.O. BOX 231, QUITMAN 31643
CALDWELL,JOSEPH L.,JR. 54 ACT SU
808 13TH ST., AUGUSTA 30901
CALDWELL,KENDALL W. 15 ACT R

CALHOUN,F. P.,JR. 29 ACT OPH
1365 CLIFTON RD. NE, ATLANTA 30322
CALHOUN,W. C. 72 ACT OB
P. O. BOX 1091, WAYCROSS 31501
CALLAWAY,GEORGE M.,JR. 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
CALVERT,JON C. 54 ACT FP
MED. COLLEGE OF GA., AUGUSTA 30902
CALVERT,WILSON C. 45 ACT I

CAMBLOR,GONZALO 17 ACT PATH
COBB GENERAL HOSP., AUSTELL 30001
CAMPA,JOSE C. 56 ACT OR
1807 JERRY JOHNS DR., VALDOSTA 31601
CAMPBELL,CLARENCE G.,JR 42 ACT R
LAURENS CO. HOSP., DUBLIN 31021
CAMPBELL,HAROLD EUGENE 12 ACT FP
46 LAUREL AVENUE, ELBERTON 30635
CAMPBELL,LEONARD H. 06 ACT PATH
548 FIRST ST., MACON 31201
CAMPBELL,RICHARD P. 27 ACT FP
1104 N. MAIN STREET, CEDARTOWN 30125
CAMPBELL,WALLACE G. 29 ACT PATH
EMORY UN. SCH. OF MEDICINE, ATLANTA 30322
CANNON,CLIFTON L.,JR. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405
CAPLAN,DANIEL B. 29 ACT PD
69 BUTLER ST. SE, ATLANTA 30303
CAPLAN,GERALD E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
CAPLAN,J. LOUIS 29 R OTO

CARAS,THOMAS S. 17 ACT I
641 CHURCH ST., MARIETTA 30062
CARBAUGH,ROBERT G. 72 ACT ANES
1921 ALICE ST., WAYCROSS 31501
CARDEN,BRADLEY L. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
CARDOSO,DAVID 02 ACT OBG
P.O. BOX 489, MILLEDGEVILLE 31062
CARGILE,KENNETH R. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CARICO,JAMES M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
CARLISLE,O. B. 29 ACT OPH
3158 MAPLE DR. NE, ATLANTA 30305
CARLOCK,KELLER S. 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305

CARLTON,FRANK E. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403
CARLUCCI,AGOSTINO 54 ACT
1108 DRUID PARK AVE., AUGUSTA 30904
CARPENTER,JAMES L. 29 ACT P
510 OAK HILL CIRCLE, MARIETTA 30060
CARPENTER,R. S. 21 ACT SU
P.O. BOX 1110, BAINBRIDGE 31717
CARPENTER,ROBERT H. 47 ACT OBG
2404 13TH ST., COLUMBUS 31906
CARR,ALBERT A. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
CARR,J. BRUCE 47 ACT NE
DOCTORS BUILDING, COLUMBUS 31901
CARR,RICHARD D. 29 S PM
3744 PREAKNESS DR., DECATUR 30034
CARRINGTON,KENNETH W. 54 ACT NS
1521 POPE AVE., AUGUSTA 30904
CARRINGTON,LOUIE H. 29 ACT PD
275 CARPENTER DR. NW, ATLANTA 30328
CARROLL,MICHAEL S. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30062
CARSON,GORDON C.,III 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
CARSON,JAMES MAXWELL 29 ACT
340 BOULEVARD NE, ATLANTA 30312
CARSON,W. P. 76 ACT SU
P. O. BOX 129, DALTON 30720
CARSPECKEN,HAROLD HUTSON 22 ACT PL
755 COLUMBIA DR., DECATUR 30030
CARSWELL,AUGUSTIN S. 54 ACT OR
3623 J.DEWEY GRAY CR., AUGUSTA 30904
CARSWELL,NELSON S.,JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021
CARTER,A. W.,JR. 29 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050
CARTER,CURTIS H. 54 ACT I
748 AUMOND RD., AUGUSTA 30904
CARTER,JAMES A. 29 ACT OTO
35 COLLIER RD. NW, ATLANTA 30309
CARTER,LEON,JR. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030
CARTER,M. GARY 06 ACT OPH
626 FIRST STREET, MACON 31201
CARTER,MARY JO 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
CARTER,OTHA B.,JR. 23 ACT SU
810-13TH AVE., ALBANY 31701
CARTER,ROBERT A. 36 ACT
212 HOSPITAL DR., WARNER ROBINS 31093
CARTER,ROBERT H. 11 ACT SU
1020 DRAYTON ST., SAVANNAH 31401
CARTER,ROBERT L. 69 DE5 FP
THOMASTON 30286
CARTER,SANDY B. 29 ACT I
1938 PTREE ST., NW #1502, ATLANTA 30327
CASEY,JESSE F. 29 A P
1929 N. RIDGEWAY RD. NE, ATLANTA 30329
CASH,TED D. 70 ACT FP
162 EUCLID AVE., CHICKAMAUGA 30707
CASKIN,CLINTON R.J.,JR. 15 ACT U
245 WESTVIEW DR., ATHENS 30601
CASON,WILLIAM M. 29 DE5 OALR
6566 GLENRIDGE DR. N.E., ATLANTA 30328
CASTILLO,ANTONIO R. 70 ACT FP
214 ANDREWS ST., ROSSVILLE 30741
CASTILLO,REUBEN 16 ACT FP
P. O. BOX 157, JONESBORO 30236
CASTLE,JOHN RICHARD 22 ACT OBG
231 E. PONCE DE LEON AVE., DECATUR 30030
CASTLEBERRY, ROBERT P. 47 S PD
4312 OLD MACON RD.,A-32, COLUMBUS 31907
CASWELL,ROBERT J.,II 59 ACT R
686 S. 8TH ST., GRIFFIN 30223
CATANZARO,MARSHALL J. 29 ACT R
3312 PIEDMONT RD. NE, ATLANTA 30305
CATES,ROBERT M. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161
CATHCART,DON F. 29 DE5 PD
490 PEACHTREE ST. N.E., ATLANTA 30308
CATO,ROBERT E. 06 ACT R
722 FIRST STREET, MACON 31201
CAUBLE,GEORGE 17 ACT
ACWORTH 30101
CAUBLE,JOHN A. 14 ACT FP
P. O. BOX 1048, CANTON 30114
CAUDILL,DARRELL R. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
CAULTON, CHARLES I. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CAUSEY,ROBERT S.,JR. 17 ACT PD
122 CHERRY ST., MARIETTA 30062
CAUTHEN,LARRY R. 27 ACT ANES
P.O. BOX 27, ROME 30161
CEBULA,JEROME M. 48 ACT PATH
2537 HIGHLAND DR., CONYERS 30207
CENTER,A. H. 11 ACT PN
10 MEDICAL ARTS CENTER, SAVANNAH 31405
CHAIT,DONALD C. 29 ACT I
490 PEACHTREE ST. N.E., ATLANTA 30308
CHALMERS,RIVES 29 ACT P
2905 PEACHTREE RD. N. E., ATLANTA 30305
CHAMBERS,BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
CHAMBERS,J. W. 68 ACT I
307 N. LEWIS ST., LAGRANGE 30240
CHAMBERS,ROY G. 54 ACT P
1423 HARPER ST., AUGUSTA 30902
CHAMBLESS,MIRIAM WALKER 45 ACT FP
HAMILTON 31811
CHAMBLESS,WILLIAM G. 45 ACT FP
HAMILTON 31811
CHANDLER,A. BLEAKLEY 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
CHANDLER,JOHN L. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
CHANDLER,NEAL W. 29 ACT R
4680 RIVERVIEW RD.,NW, ATLANTA 30327
CHANEY,RALPH H.,JR. 30 ACT ANES
P.O. BOX 776, BRUNSWICK 31520
CHANG,LUNG-HSIUNG 13 ACT OPH
1300 W. PIKE PL., LAWRENCEVILLE 30245
CHANNA,G. H. 22 ACT PD
4705 LAWRENCEVILLE HWY., LILBURN 30247
CHAPPELL,AMEY 29 DE5 I
3750 PEACHTREE ST. NE, ATLANTA 30319
CHASE,JERRY S. 47 I&R FP

CHASTAIN,GEORGE M. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702
CHASTAIN,J. B. 47 ACT PD
1710 HILTON AVE., COLUMBUS 31906
CHEATHAM,JAMES S. 76 ACT P
201 S. HAMILTON ST., #408, DALTON 30720
CHELTON,ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
CHELTON,L. GUY 29 ACT I
1999 CLIFF VALLEY WAY NE, ATLANTA 30329
CHEN,ER-WEI 58 ACT FP
172 PINE AVE.,SW, GRIFFIN 30223
CHENG,YUNG-SHENG 11 ACT OBG
8508 KENT DR., SAVANNAH 31406
CHEVES,H. L. 29 ACT FP
2726-B FELTON DR., EAST POINT 30344
CHEVRES, FRANCISCO, 76 S FP
1401 BURLEYSON DR., DALTON 30720
CHIPMAN,R. A. 47 ACT SU
PHYSICIANS BLDG., COLUMBUS 31901
CHISHOLM,LEWIS F. 56 ACT FP
ROBBINS CLINIC, HOMERVILLE 31634
CHOI,SUN IK 68 ACT ANES
801 CHEROKEE RD., LAGRANGE 30240
CHORCHES,MICHAEL A. 29 ACT C
265 IVY ST. NE, ATLANT 30303
CHRISTENSEN,EUNICE H. 65 R ANES
J. D. ARCHBOLD HOSP., THOMASVILLE 31792
CHRISTENSEN,EVERETT D. 65 ACT FP
J. D. ARCHBOLD HOSP., THOMASVILLE 31792
CHRISTIAN,J. D.,JR. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904

CHRISTMAS,JOSEPH T. 26 ACT FP
VIENNA 31092
CHRISTOPHER,PHILIP E. 22 ACT SU
365 WINN WAY, DECATUR 30032
CHRISTY,JAMES H. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
CHUNG,SOONG PYO 42 ACT PATH
VA CENTER, DUBLIN 31021
CHYATTE,SAMUEL B. 29 ACT PM
EMORY UNIV. HOSP., ATLANTA 30322
CIBELLI,LOUIS A. 29 R R
257 COLONIAL HOMES DR. NW, ATLANTA 30309
CIRINCIONE,V. J. 11 ACT D
46 MEDICAL ARTS CENTER, SAVANNAH 31405
CLABBY,JAMES W. 17 ACT I
1642 MULKEY RD. SW, AUSTELL 30001
CLAIBORNE,T. STERLING 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
CLAIR,ALVIN H. 29 ACT D
4720 OLD VILLAGE LN. NE, ATLANTA 30341
CLARK,F. B. 17 ACT FP
AUSTELL 30001
CLARK,JAMES E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
CLARK,NEWTON T.,JR. 29 ACT OR
275 CARPENTER DR. NE, ATLANTA 30328
CLARK,NILE R. 15 ACT FP
1160 PRINCE AVE., ATHENS 30601
CLARK,PATRICIA D. 54 I&R
MCG, BO 898, AUGUSTA 30902
CLARK,REMER Y.,JR. 17 ACT FP
1422 CHEROKEE ST., MARIETTA 30062
CLARK,ROLAND B. 30 ACT OPH
4226 8TH ST.,E.BEACH, ST. SIMON'S IS. 31522
CLARK,SARAH L. 54 ACT I
3651 WHEELER RD., AUGUSTA 30904
CLARK,SPURGEON WM.,JR. 72 ACT OPH
P. O. BOX 951, WAYCROSS 31501
CLARK,WILLIAM L.,JR. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
CLARKE,GEORGE D. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
CLARY,THOS. L.,JR. 54 ACT I
712 OBERLIN ROAD, AUGUSTA 30904
CLARY,W. UPTON 11 ACT NS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
CLAY,CALDER B.,JR. 06 ACT SU
724 HEMLOCK ST., MACON 31201
CLAY,HENRY T. 06 ACT FP
1640 COLEMAN AVE., MACON 31201
CLAY,JAMES R. 15 ACT PATH
ATHENS GENERAL HOSPITAL, ATHENS 30601
CLAYTON,EDWARD C. 02 ACT R
BOX 231, IRWINTON 31042
CLAYTON,MAX L. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
CLEMENTS,FRED N. 56 ACT FP
ADEL 31620
CLEMENTS,J.L.,JR. 29 ACT I
4055 RANDALL MILL RD. NW, ATL. 30327
CLEMENTS,STEPHEN D. 29 ACT C
1365 CLIFTON RD. NE, ATLANTA 30322
CLEMONS,THURMAN 08 ACT FP
P. O. BOX 821, STATESBORO 30458
CLINE,PETER J. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
CLINE,STEVEN G. 29 ACT G
1170 CLEVELAND AVENUE, EAST POINT 30344
CLINKSCALES,GRADY S. JR. 29 ACT OR
1938 PEACHTREE RD,NE,STE 603, ATLANTA 30309
CLONTS,W. T. 17 ACT R
70 TOWER RD., MARIETTA 30061
CLOUSE,JOHN E.,JR. 59 ACT FP
682 S. 8TH ST., GRIFFIN 30223
COATES,GRAHAM 23 ACT P
1112 N. MADISON, ALBANY 31705
COBB,CLAUD P.,JR. 29 ACT FP
1544 NISKEYLAKE TR., SW, ATLANTA 30331
COBB,ELLIOTT A. 11 ACT
P.O. BOX 6688, STA. C, SAVANNAH 31405
COBBS,BEVERLY W.,JR. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
COBERLY,JAMES CHAPMAN 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
COCHRAN,E. B. 17 ACT SU
641 CHURCH ST., MARIETTA 30060
COCHRAN,T. A. 70 ACT FP
RINGGOLD 30736
CODINGTON,ARTHUR B. 22 ACT I
2647 CANDLER PKWY., DECATUR 30032
COE,H. M. 30 ACT OR
2601 PARKWOOD DR., BRUNSWICK 31520
COFFSKY,JAY S. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
COGDELL,B. H. 18 ACT FP
ALMA 31510
COGGINS,ROBERT P. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062
COHEN, LARRY 15 ACT R
190 BROOMSEDGE TR.,, ATHENS 30601
COHEN,DAVID M. 29 ACT OTO
6500 VERNON WOODS DR. NE, ATLANTA 30328
COHEN,I. R. 29 ACT PD
950 W. PEACHTREE ST. N. E., ATLANTA 30309
COHEN,JACK H. 17 ACT SU
NAVAL AIR STATION, MARIETTA 30062
COHEN,LAWRENCE 16 ACT OBG
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
COHEN,MARSHALL 29 ACT D
490 PEACHTREE ST. NE, ATLANTA 30308
COHEN,MARVYN D. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
COHEN,PAUL G. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
COHEN,RICHARD W. 17 ACT OR
1676 MULKEY RD., AUSTELL 30001
COHEN,ROBERT A. 29 ACT I
2250 WINDY HILL RD., MARIETTA 30062
COHEN,SHELDON B. 29 ACT P
401 PEACHTREE ST. N. E., ATLANTA 30308
COHENOUR,JEFFREY H. 15 ACT PATH
BOX 946, MONROE 30655
COHN,PERRY L. 06 ACT NS
740 HEMLOCK ST., MACON 31201
COKER,GRADY N. 14 DE5 SU
150 HOSPITAL CIRCLE, CANTON 30114
COLDITZ,RICHARD B. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
COLEMAN,BLANCHE D. 54 ACT OBG
1450 ANTHONY RD., AUGUSTA 30904
COLEMAN,FRANCIS,W. W. 56 ACT I
501 WOODROW WILSON DR., VALDOSTA 31601
COLEMAN,FRED J. 42 ACT SU
106 N. CHURCH ST., DUBLIN 31021
COLEMAN,OTHA K. 26 ACT FP
CORDELE 31015
COLEMAN,REESE C.,JR. 29 ACT U
401 PEACHTREE ST. N. E., ATLANTA 30308
COLEMAN,W. E. 50 ACT FP
HAWKINSVILLE 31036
COLEMAN,WILLIAM MCL. 23 ACT OR
810 14TH AVE., ALBANY 31705
COLES,CLEO P.,JR. 29 ACT SU
2945 STONE HOGAN RD.CONN. SW, ATLANTA 30331
COLES,W. C. 29 ACT R
315 BOULEVARD,NE, ATLANTA 30312
COLIER,HOWARD J. 10 ACT OR
6287 FAIRBURN RD., DOUGLASVILLE 30134
COLLIER,HAL F. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
COLLINGS,HAROLD,JR. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904
COLLINS,BRASWELL E. 06 ACT OPH
2635 STANISLAUS CIR., MACON 31204
COLLINS,CHAPPELL A.,JR. 23 ACT FP
810 13TH AVE. , ALBANY 31701
COLLINS,FRANK B. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
COLLINS,JAMES E. 45 ACT FP
129 E. SECOND STREET, MANCHESTER 31816

COLLINS,JOHN T. 27 ACT OBG
206 HOSPITAL CIRCLE, ROME 30161
COLLINS,LEWIS R. 20 ACT I
P. O. BOX 609, NEWNAN 30263
COLLINS,MYRON D. F. 54 ACT OR
1132 DRUID PARK DR., AUGUSTA 30904
COLLINS,ROBERT A. 61 ACT SU
212 REESE ST., AMERICUS 31709
COLLINS,WILLIAM C. 29 ACT OR
275 CARPENTER DR. NE, ATLANTA 30328
COLMERS,RUDOLF A. 11 ACT I
217 E HUNTINGDON ST., SAVANNAH 31401
COLON,LUIS M. 02 ACT OBG
CLODFELTER APT.2,CSH, MILLEDGEVILLE 31061
COLQUITT,ALFRED O.,III 17 ACT OR
732 CHEROKEE ST., MARIETTA 30060
COLQUITT,ALFRED O.,JR. 17 ACT OBG
1205 ROSWELL ST., MARIETTA 30062
COLQUITT,HUGH S. 17 ACT
615 ROSWELL STREET, MARIETTA 30062
COLVIN,RICHARD S. 22 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
CONGER,A. B. 47 ACT SU
206 DOCTORS BLDG., COLUMBUS 31901
CONGER,P. D. 19 ACT FP
MOULTRIE 31768
CONN,LEE R. M. 47 ACT SU
1914 8TH AVE., COLUMBUS 31901
CONNELL,H. C. 06 ACT R
MACON HOSP., MACON 31201
CONNELL,H. R.,JR. 27 ACT OALR
HARBIN CLINIC, ROME 30161
CONNER,D. H. 50 ACT
P. O. BOX 629, EASTMAN 31023
CONNER,GEORGE R. 47 ACT SU
1914 8TH AVE., COLUMBUS 31901
CONNER,H. I. 57 ACT SU
P. O. BOX 1107, VIDALIA 30474
CONNER,WILLIAM C. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
CONNOR,ROBERT T. 27 ACT FP
101 JOHN MADDOX DR., ROME 30161
CONOLEY,KENNETH 60 ACT PD
304 N. SAGE, TOCCOA 30577
CONRAD,CONSTANCE C. 29 A FP
1069 BURTON DR. NE, ATLANTA 30329
COOK,ARTHUR J. 29 ACT R
478 PEACHTREE ST. NE, ATLANTA 30308
COOK,ERNEST L. 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30904
COOK,ROGER P. 29 ACT
3957 RANDALL MILL RD,NW, ATLANTA 30327
COOK,TERRENCE J. 54 ACT I
1715 1/2 CENTRAL AVE., AUGUSTA 30904
COOK,WM. C.,JR. 29 ACT ANES
3113 FARMINGTON DR. NE, ATLANTA 30339
COOLEDGE,JOHN W. 29 ACT PD
4770 N. PEACHTREE RD., CHAMBLEE 30341
COOLEY,SARAH F. 29 A
3686 CREEKVIEW CIR., STONE MOUNTAIN 30083
COONEY,JAMES P. 29 R
3653 N. STRATFORD RD. NE, ATLANTA 30305
COOPER,CHARLES F.,JR. 29 R OPH
1851 COLLAND DR. NW, ATLANTA 30318
COOPER,FLOYD C.,III 59 ACT P
306 S. 8TH ST., GRIFFIN 30223
COOPER,FLOYD R.,JR. 29 ACT NS
2718 FELTON DR., EAST POINT 30344
COOPER,GERALD R. 29 S I
CDC CENTER, ATLANTA 30333
COOPER,HARRY A. 29 ACT I
3393 PTREE RD. NE, ATLANTA 30326
COOPER,JAMES T. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30062
COOPER,JERRY L. 22 ACT
3300 MEMORIAL DR., DECATUR 30032
COOPER,LAWRENCE E. 29 ACT I
2540 WINDY HILL RD., MARIETTA 30062
COPELAN,ELTON L. 60 ACT OBG
TOCCOA CLINIC, TOCCOA 30577
COPELAND,FRANK H. 06 ACT P
MED. CTR. OF CENTRAL GA., MACON 31208
COPELAND,H. J. 59 DE1 SU
615 E. COLLEGE ST., GRIFFIN 30223
COPELAND,ROBERT B. 68 ACT I
303 SMITH ST., LAGRANGE 30240
COPLIN,PAULR., R. 29 A P
1445 MONROE DR.,NE,F-30, ATLANTA 30324
COPPEDGE,W. W. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
CORDER,V. WOODARD 68 ACT ANES
P.O. BOX 191, WEST POINT 31833
CORLEY,C. C. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
CORPE,R. F. 27 ACT SU
BATTEY STATE HOSP., ROME 30161
CORRY,ROBERT D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CORTES,JULIO P. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
COSTA,CONRADO V.,JR. 11 ACT FP
P. O. BOX 9787, SAVANNAH 31402
COTTS,LEONARD L. 22 ACT I
3648 CHAMBLEE TUCKER RD., ATLANTA 30341
COUNCIL,BENJAMIN P. 76 ACT OTO
1305 BROADRICK DR., DALTON 30720
COURSON,HERMAN C. 65 ACT I
P. O. BOX 1939, THOMASVILLE 31792
COUSINS,ALBERT L. 68 S I
303 SMITH ST., LAGRANGE 30240
COWAN,MORGAN A. 06 ACT NS
740 HEMLOCK ST., MACON 31201
COWAN,Z. S. 29 R FP
1179 CLIFTON ROAD NE, ATLANTA 30316
COWART,CHARLES T. 68 ACT SU
718 LA ROSE TERR., LAGRANGE 30240
COWART,G. THOMAS 29 ACT U
384 PEACHTREE ST. N. E., ATLANTA 30308
COWEN,FREDERICK B. 29 ACT EM
501 FAIRURN RBURN RD.,SW, ATLANTA 30331
COX,CHARLOTTE T. 06 ACT OBG
380 HOSPITAL DR., MACON 31201
COX,GEORGE W. 29 A R
1365 CLIFTON RD.,NE, ATLANTA 30322
COX,JOEL E. 59 ACT OBG
503 SOUTH 8TH ST, GRIFFIN 30223
COX,ROSS J. 29 ACT FP
6363 ROSWELL RD. NE, ATLANTA 30328
COXWELL,WAYNE L. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
CRAIG,JAMES B. 02 ACT P
P.O. BOX 13607, SAVANNAH 31406
CRANK,R. PAUL 22 ACT I
755 COLUMBIA DR., DECATUR 30030
CRANMAN,JERARD S. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
CRARY,ELY J. 17 ACT OPH
4730 AUSTELL RD., AUSTELL 30001
CRAVER,JOE M. 29 ACT TS
25 PRESCOTT ST. NE, ATLANTA 30308
CRAWFORD,CARL L. 36 ACT FP
1410 WATSON RD., WARNER ROBINS 31093
CRAWFORD,CLYDE L. 29 ACT SU
652 W. PEACHTREE ST. N. W., ATLANTA 30308
CRAWFORD,GLENN D. 17 ACT R
COBB GENERAL HOSP., AUSTELL 30001
CRAWFORD,JOHN B. 59 ACT FP
BARNESVILLE 30204
CRAWLEY,WILLIAM D. 70 ACT OBG
787 CHICKAMAUGA AVE., ROSSVILLE 30741
CREAGH,GERARD B. 15 DE1 PH
555 MILLEDGE CIR., ATHENS 30601
CREECH,EARL L. 56 ACT OR
P. O. BOX 2261, VALDOSTA 31601
CRENSHAW,JOHN T. 37 ACT FP
P. O. BOX 219, JEFFERSON 30549
CRIDER,HARRY J.,JR. 29 ACT OBG
1135 SHERIDAN RD. NE, ATLANTA 30324
CRIMMINS,L.T. 23 ACT SU
1009 N. MONROE, ALBANY 31701

CRISLER,EUGENE C. 54 ACT R
P.O. DRAWER 930, CHESTER,SC 29706
CRISPIN,ROY H. 22 ACT TS
365 WINN WAY, DECATUR 30030
CROFT,THOMAS J. 29 ACT NS
2718 FELTON DR., EAST POINT 30344
CRONCE,PAUL C. 29 ACT D
3316 PIEDMONT RD,NE,STE 50, ATLANTA 30305
CROOMS,C.L. 29 ACT OR
960 JOHNSON FERRY RD.,NE, ATLANTA 30342
CROSBY,WILLIAM V. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
CROSS,JAMES LEE 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
CROSSE,JAMES E.W. 47 S U
MARTIN ARMY HOSPITAL, FT. BENNING 31905
CROUCH,MICKEY M. 54 DE2 FP
MEDICAL COLLEGE OF GA., AUGUSTA 30902
CROW,ROBERT W. 29 ACT PL
3280 HOWELL MILL RD.,NW, ATLANTA 30327
CROWDER,JACKSON G. 47 ACT I
PHYSICIAN'S BLDG., COLUMBUS 31901
CROWDIS,JAS. HUDSON,JR. 58 ACT
BLAKELY 31723
CROWE,WILLIAM R. 29 ACT I
1218 WEST PACES FY RD, ATLANTA 30327
CRUISE,JOE S. 29 ACT PUL
384 PEACHTREE ST. N. E., ATLANTA 30308
CRUMBLEY,A. J.,JR. 29 ACT SU
2788 BAYARD ST., EAST POINT 30344
CRUTCHER,JAMES CARROLL 29 S
1670 CLAIRMONT RD. NE, DECATUR 30033
CRYMES,JOHN M. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAV 31405
CUETO,JOSE R. DEL 29 ACT FP
2739 FELTON DR., EAST POINT 30344
CULBRETH,ERNEST W. 27 ACT FP
319 W. 6TH ST., ROME 30161
CUMMINGS,ROBERT J.,JR. 29 A OR
300 BOULEVARD NE, ATLANTA 30312
CUMMINGS,T. E. 27 ACT FP
121 E. MAPLE ST., ROCKMART 30153
CUNDEY,DAVID W. 54 ACT C
1003 CHAFFEE AVE., AUGUSTA 30902
CUNDEY,PAUL E.,JR. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904
CUNNINGHAM,ROBERT P. 29 ACT I
SOUTHERN BELL, BOX 2211, ATLANTA 30301
CURCIC,DESANKA V. 29 ACT PD
1029 RIDGE AVE.,SW, ATLANTA 30325
CURETON,M. K. 70 DE5 PH
6 SUNSET DR., LAFAYETTE 30727
CURETON,RICHARD K. 70 ACT R
HUTCHESON HOSP., FT. OGLETHORPE 30742
CURIEL,HECTOR J. 17 ACT FP
8530 HOSPITAL DR., DOUGLASVILLE 30134
CURRY,LEON E. 08 ACT FP
P. O. BOX 267, METTER 30439
CURRY,VIRGIL L. 17 ACT U
2404 AUSTELL-MARIETTA RD., AUSTELL 30001
CURTIS,EARNEST M.,JR. 29 ACT OBG
275 CARPENTER DR., SANDY SPRINGS 30328
CURTIS,JOHN R. 15 ACT P
UNIV. HEALTH SERV., ATHENS 30601
CURTIS,THOMAS H. 70 ACT OBG
1816 LAFAYETTE RD., FT. OGLETHORPE 30742
CURTIS,WALKER L. 29 DE1 I
P. O. BOX 87100, COLLEGE PARK 30337
CUSTY,JANE C. 54 ACT ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30902
CUTTS,WILLIAM G.,JR. 14 ACT SU
P. O. BOX 962, CANTON 30114

D

DAILY,F. WILLSON 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
DAITCH,RONALD 54 ACT OBG
1021-15TH ST., AUGUSTA 30901
DALLAS,R. E. 69 ACT FP
211 E. THOMASTON ST., THOMASTON 30286
DALLAS,WM. M.,JR. 69 ACT SU
405 W. MAIN ST., THOMASTON 30286
DALRYMPLE,DAVID E. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
DALTON,WILLIAM E. 31 ACT FP
105 E. 40TH DR., CALHOUN 30701
DALY,FRANK T.,JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
DANIEL,A. B. 08 ACT SU
P. O. BOX 717, STATESBORO 30458
DANIEL,ERNEST F.,JR. 54 ACT NS
3623 J. DEWEY GRAY CIRCLE, AUGUSTA 30904
DANIEL,J.W.,JR. 06 ACT
1383 OGLETHORPE ST., MAON 31201
DANIEL,WM. W. 29 ACT OBG
5675 PTREE-DUNWOODY RD, NE, ATLANTA 30342
DANZIG,LAMONT EARL 11 ACT I
P. O. BOX 5086, SAVANNAH 31403
DARBY,V. L. 57 DE5 SU
706 CHURCH ST., VIDALIA 30474
DARDIN, M. VICTOR, 76 ACT OBG
P.O. BOX 989, DALTON 30720
DARNELL,D.T. 14 ACT FP
TATE 30177
DASHER,WILLIAM B.,JR 06 ACT OR
380 HOSPITAL DR., MACON 31201
DASHIELL,WAVERLY B. 47 ACT OBG
P. O. BOX 157, COLUMBUS 31902
DAVENPORT,T. F. 29 DE5 PD
478 PEACHTREE ST. NE, ATLANTA 30308
DAVIDSON, JOHN A. 29 ACT OPH
478 PEACHTREE ST.,NE, ATLANTA 30308
DAVIDSON,EUGENE D. 29 ACT SU
1365 CLIFTON RD.,NE, ATLANTA 30322
DAVIDSON,GENE G. 27 ACT I
HARBIN CLINIC, ROME 30161
DAVIDSON,JOHN K.,III 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
DAVIES,NICHOLAS E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
DAVIES,ROBERT L. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
DAVIS,ALBERT M. 29 ACT I
75 PIEDMONT AVE. NE, ATLANTA 30303
DAVIS,ALFRED L.,JR. 72 ACT PD
P. O. BOX 71, BLACKSHEAR 31516
DAVIS,BILLY J. 28 ACT FP
GIBSON ST., HARTWELL 30643
DAVIS,BYRON S. 56 ACT PATH
P.O. BOX 2658, VALDOSTA 31601
DAVIS,DAVE M. 29 ACT P
1999 CLIFF VALLEY WAY NE, ATLANTA 30329
DAVIS,F. MORRIS 66 ACT FP
820 TIFT AVE., TIFTON 31794
DAVIS,FELTZ C. 06 DE5 ALR
745 PINE ST., MACON 31201
DAVIS,FLOYD E. 72 ACT FP
1921 ALICE ST., WAYCROSS 31501
DAVIS,FLOYD L. O. 29 ACT OPH
2722-A FELTON DR., EAST POINT 30344
DAVIS,H. G.,JR. 79 ACT FP
SYLVESTER 31791
DAVIS,JOHN L.,III 29 ACT OPH
3200 HOWELL MILL RD. NW, ATLANTA 30327
DAVIS,JOSEPH R. 29 ACT FP
6701 ROSWELL RD. NE, ATLANTA 30328
DAVIS,LAWRENCE P. 04 ACT SU
P.O. BOX 764, CARTERSVILLE 30120
DAVIS,M. BEDFORD,JR. 29 ACT SU
340 BOULEVARD N.E., ATLANTA 30312
DAVIS,MARVIN L. 29 ACT PD
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
DAVIS,MATTHEW E. 16 ACT OALR
33 S.W. UPPER RVRDALE RD., JONESBORO 30274
DAVIS,R. CARTER,JR. 29 ACT I
1201 PTREE ST. NE, ATLANTA 30361
DAVIS,RALPH J. 27 ACT SU
P. O. BOX 2227, ROME 30161

DAVIS,REX 47 S FP
MARTIN ARMY HOSP., FT. BENNING 31905
DAVIS,ROBERT S. 29 ACT OBG
2100 PARKLAKE DR. NE, ATLANTA 30345
DAVIS,SHELLEY C.,JR. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
DAVIS,TERRELL L. 66 ACT PD
418 N. PARK, TIFTON 31794
DAVIS,THOMAS A. 29 ACT P
1999 CLIFF VALLEY WAY, ATL. 30329
DAVIS,THOMAS NED 06 ACT FP
IRWINTON 31042
DAVIS,WILKES H.,JR. 17 ACT OPH
653 CHEROKEE ST. NE, MARIETTA 30060
DAVIS,WILLIAM A.,III 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
DAVIS,WILLIAM B. 29 R PD
2065 WALKER AVE., COLLEGE PARK 30337
DAVIS,WILLIAM S. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
DAVIS,WILLIAM S. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
DAVISON,ALEXIS H. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
DAWSON,JACK E.,JR. 29 DE4 I
2225 RIADA DR. NW, ATLANTA 30305
DE ARMAS,F.M. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
DE BRA,DON W.,JR. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033
DE LA PERRIERE,ARMAND 29 ACT OBG
3626 CHAMBLEE TUCKER RD, CHAMBLEE 30341
DE LAOSA,MARIO O. 02 ACT SU
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
DE LEMOS,GASTON P. 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
DE REAMER,JOHN W. 11 DE1 D
2917 WEYMAN ST #20, SHREVEPORT, LA. 71104
DEAL,ALBERT M. 08 ACT SU
P. O. BOX 647, STATESBORO 30458
DEAL,HELEN R. 08 ACT PD
P. O. BOX 647, STATESBORO 30458
DEAL,JOHN D. 08 ACT FP
P. O. BOX 1043, STATESBORO 30458
DEAN,CHARLIE W. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030
DEAN,ROBERT D. 47 ACT OBG
110 DOCTORS BLDG., COLUMBUS 31901
DEAS,RALPH H. 29 DE1 OPH
3166 MAPLE DR., ATLANTA 30305
DEATON,J. H. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
DEEN,JOHNNY T. 69 ACT OPH
THOMASTON 30286
DEES,HOYT C. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
DEITCH,MILTON J. 29 ACT U
490 PEACHTREE STREET NE, ATLANTA 30308
DEJARNETTE,ROBERT H.,JR 57 ACT SU
702 MEADOWS LANE, VIDALIA 30474
DEKLE,JOHN L.,JR. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
DEL RIO,GABRIEL G. 11 ACT PD
P. O. BOX 6688, SAVANNAH 31405
DELANCY,HERMAN 11 ACT SU
5102 PAULSEN ST., SAVANNAH 31405
DELASHMUTT,ROBERT E. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
DELATORRE,JOSE M. 02 ACT P
153 RIVERSIDEDR., MILLEDGEVILLE 31061
DELGADO,JOSE A. 02 ACT P
COLLEGE ST., MONTICELLO 31064
DELLINGER,RAIDEN W. 27 ACT SU
321 W. 7TH ST., ROME 30163
DELLINGER,RAY E. 17 ACT SU
3001 S. COBB DR. SE, SMYRNA 30080
DELOACH,ERVIN D. 11 I&R SU
BOX 6688, STA C, SAVANNAH 31405
DEMPSEY,JAMES E. 15 ACT OTO
1010 PRINCE AVE., ATHENS 30601
DENIS,BRUNO 29 ACT FP
427 KING ARNOLD DR., HAPEVILLE 30354
DENMARK,L. D. 29 DE5 PD
5605 GLENRIDGE DR. N. E., ATLANTA 30305
DENNARD,JAMES E. 56 ACT OALR
DOCTORS BLDG, STE. 108, VALDOSTA 31601
DENNEY,ROY L. 10 ACT OALR
CARROLLTON 30117
DENNIS,ALLEN J.,JR. 54 ACT I
TALMADGE MEM. HOSP., AUGUSTA 30902
DENNIS,BROWN W. 29 ACT I
35 COLLIER RD.,NW, ATLANTA 30309
DENNISON,DAVID B. 29 ACT I
3280 HOWELL MILL RD.,NW, ATLANTA 30327
DENSLER,JAMES F. 29 ACT SU
319 W. LAKE AVE., ATLANTA 30318
DEREBAIL,GOPALAKRISHNA 06 ACT EM
4923-F RIVOLI DR., MACON 31204
DERISO,H. CLARK 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405
DERRICK,HOWARD C.,JR. 70 ACT FP
LAFAYETTE 30728
DEVORE,MARGARET B. 54 ACT ANES
MED. COLL. OF GA., AUGUSTA 30902
DEW,J. HARRIS 29 ACT SU
3250 HOWELL MILL RD. NW, ATLANTA 30327
DEW,J. HARRIS,JR. 29 ACT OPH
3158 MAPLE DR. NE, ATLANTA 30305
DI BENEDETTO,ROBERT J. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405
DIAZ,EVELIO F. 02 ACT P
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31061
DICKENS,C. H. 49 DE5 PD
903 DIXIE AVE., MADISON 30650
DICKENS,WINBURN J. 03 ACT FP
802 EAST AVE., WINDER 30680
DICKEY,L. E.,JR. 06 ACT OR
380 HOSPITAL DR., MACON 31201
DICKINSON,JOHN I. 27 ACT SU
310 W. SIXTH ST., ROME 30161
DICKINSON,RICHARD F. 23 ACT R
P.O. BOX 1924, ALBANY 31702
DICKSON,WILLIAM A. 56 ACT FP
408 E. STANFILL, HAHIRA 31632
DILIBERTI,CHARLES P. 06 ACT R
4754 OXFORD RD., MACON 31204
DILLARD,GARY A. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
DILLARD,WILLIAM B.,JR. 04 ACT FP
P. O. BOX 468, CARTERSVILLE 30120
DIMON,JOS. H. III 29 ACT OR
1938 PEACHTREE RD. NW, ATLANTA 30309
DIMOND,KEITH A. 11 ACT NE
P. O. BOX 5086, SAVANNAH 31405
DIMOU,THEOFANIS G. 27 ACT FP
FLOYD HOSPITAL, ROME 30161
DINNERSTEIN,ALLAN J. 16 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236
DINOLOV,JORDAN V. 26 ACT FP
P.O. BOX 232, ASHBURN 31714
DISMUKE,JAMES C. 56 ACT FP
P. O. BOX 409, ADEL 31620
DIXON,ELLIS H.,JR. 15 ACT OBG
1010 PRINCE AVENUE, ATHENS 30601
DIXON,HAMILTON S. 27 ACT ALR
15 JOHN MADDOX DR., ROME 30161
DIXON,JIMMY L. 30 ACT PL
3204 SHRINE RD., BRUNSWICK 31520
DIXON,JOHN M. 22 ACT OPH
12 LAVISTA PER. OFF. PK., TUCKER 30084
DIXON,P.K. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
DIXON,SAMMIE 66 ACT OBG
1493 KENNEDY RD., TIFTON 31794
DIXON,WILLIAM L. 54 ACT SU
MCG, DEPT. SURG., AUGUSTA 30902
DOBBS,NELSON B.,JR. 27 ACT OPH
103 JOHN MADDOX BLVD, ROME 30161
DOBES,WILLIAM L.,JR. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308

DODD,JOHN S.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
DODD,WILLIAM ASA 42 ACT FP
P.O. BOX 257, WRIGHTSVILLE 31096
DODELIN,R. A. 47 ACT
2300 MANCHESTER RD #E1, COLUMBUS 31904
DODGEN,CHARLES W. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
DOHRMANN,DAVID M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
DOLAN,JOSEPH A. 68 ACT OBG
311 S. LEWIS ST., LAGRANGE 30240
DOMINGOS,WM. R. 06 ACT PD
187 PIERCE AVE., MACON 31204
DOMINY,DALE E. 29 ACT SU
3988 ASHENTREE DR., ATLANTA 30341
DONNER,ROBERT S. 06 ACT PATH
P. O. BOX 6000, MACON 31208
DOOLAN,JOHN J.,JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
DOOLEY,WILLIAM D. 27 ACT R
P. O. BOX 2625, ROME 30161
DORNEY,EDWARD R. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322
DOSS,MELVIN C. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
DOUGLAS,JOHN S.,JR. 22 ACT C
EMORY UNIVERSITY CLINIC, ATLANTA 30322
DOUGLASS,THOMAS G. 54 ACT I
1407 GWINNETT ST., AUGUSTA 30902
DOURRON,MARIA L. 22 ACT OBG

DOURRON,NESTOR W. 22 ACT FP
2900 GREENBROOK WYA, DECATUR 30030
DOVE,DONALD V. 13 ACT FP
44 S. CLAYTON ST., LAWRENCEVILLE 30245
DOWDA,F. W. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
DOWLING,GEORGE BRACKETT 29 DE5 I
1 WEST COURT SQ. #300, DECATUR 30035
DOWMAN,CHARLES E. 29 ACT NS
478 PEACHTREE ST. N.E., ATLANTA 30308
DOWMAN,CORDELIA K. 29 A PD
2550 BROOKDALE DR. NW, ATLANTA 30305
DOWNEY,W. P. 10 ACT FP
TALLAPOOSA 30176
DOWNING,EDWARD F. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405
DOXEY,CLEM M.,JR. 17 ACT D
114 CHERRY ST #E, MARIETTA 30060
DRAKE,CHAS. H. 57 ACT FP
121 N. CASWELL, GLENNVILLE 30427
DRAKE,HENRY C. 16 ACT FP
PEACHTREE CITY 30214
DRESSLER,MARIAN S. 22 ACT PH
777 HOUSTON MILL RD. NE, #5, ATLANTA 30329
DRURY,CARL M. 24 ACT FP
BOX DDD, ST. MARYS 31558
DRURY,WILEY L. 56 ACT ANES
P.O. BOX 1727, VALDOSTA 31601
DUANE,LAWRENCE .,JR 72 ACT R
P.O. BOX 938, WAYCROSS 31501
DUARTE,CARLOS R. 22 ACT PD
365 WINN WAY, DECATUR 30030
DUARTE,PATTY 22 ACT I
365 WINN WAY, DECATUR 30030
DUBOIS,RICHARD E. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
DUBOSE,BOLLING S.,JR. 15 ACT I
225 S. MILLEDGE, ATHENS 30601
DUBOSE,LIGE MOULTRIE 17 ACT OPH
1205 ROSWELL STREET, MARIETTA 30062
DUDLEY,A. B.,JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
DUDLEY,A. G. 61 DE4 OBG
205 S. LEE ST., AMERICUS 31709
DUDLEY,JAMES C. 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
DUFFELL,GORDON M. 29 ACT I
1365 CLIFTON RD.,NE, ATLANTA 30322
DUGGAN,A. DAN 78 ACT FP
P. O. BOX 370, WASHINGTON 30673
DUGGAN,C. A.,JR. 06 ACT FP
380 HOSP. DR., MACON 31201
DUHON,FRED J. 70 ACT FP
DOCTORS CLINIC, LAFAYETTE 30728
DUKE,GRADY F. 59 ACT SU
436 S . HILL ST., GRIFFIN 30223
DUKE,JOHN F.,III 36 ACT FP
BOX 131, FT. VALLEY 31030
DULL,MARTHA KATHERINE 22 ACT OBG
4330 LAVISTA RD., TUCKER 30084
DULOCK,MALCOLM P. 29 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071
DUMAIS,ALCID F. 39 ACT SU
1067 PEACHTREE ST., LOUISVILLE 30434
DUNAGAN,DONALD 54 ACT PD
1331 MONTEGO PLACE, AUGUSTA 30904
DUNAWAY,JAMES BOYD 59 ACT PD
712 S. 8TH STREET, GRIFFIN 30223
DUNAWAY,MARSHALL C. 65 ACT I
900 GORDON AVE., THOMASVILLE 31792
DUNBAR,ERNEST A.,JR. 16 ACT PD
1035 MAIN ST., FOREST PARK 30050
DUNBAR,GEORGE W. 24 ACT
P.O. BOX 767, ST. MARYS 31558
DUNBAR,RONALD W. 29 ACT ANES
1365 CLIFTON RD.,NE, ATLANTA 30322
DUNBAR,WALTER S. 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308
DUNCAN,G. A. 22 DE5 FP
714 S. CANDLER STREET, DECATUR 30030
DUNCAN,J. HARRY 11 ACT OPH
3025 BULL ST., SAVANNAH 31405
DUNCAN,ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
DUNLAP,DICKSON B. 54 ACT I
VA HOSP., AUGUSTA 30904
DUNN,BYRON H. 22 ACT OBG
7 LAVISTA PER OFC PK,102, TUCKER 30084
DUNN,LAURENCE B. 11 DE5 FP
P. O. BOX 205, BLUFFTON, S. C. 29910
DUNN,MAURICE 54 ACT P
3012 PARK AVE., AUGUSTA 30904
DUNN,ROBERT G.,JR. 23 ACT R
P.O. BOX 1924, ALBANY 31702
DUNN,WM. R. 13 ACT
P. O. BOX 668, CUMMING 30130
DUNSTAN,EDGAR M. 29 DE5 I
710 PINETREE DR., DECATUR 30030
DUPONT,LOUIS 47 ACT SU
P. O. BOX 4199, COLUMBUS 31904
DUPREE,J. T. 42 S SU
VA CENTER, DUBLIN 31021
DUPREE,THOMAS E. 06 ACT FP
577 WALNUT ST., MACON 31201
DURALDE,FERNANDO U. 29 ACT SU
2760 FELTON DR., EAST POINT 30344
DURDEN,CHARLES H. 05 ACT FP
P. O. BOX 480, FITZGERALD 31750
DURDEN,JOHN G.,JR. 47 ACT SU
1915 SEVENTH AVE., COLUMBUS 31901
DURDEN,MARK D.,III 06 ACT FP
1383 OGLETHORPE ST., MACON 31201
DURHAM,BON M. 61 ACT I
142 S. JACKSON ST., AMERICUS 31709
DURHAM,W. P. 50 DE5 OALR
1410 HUMMINGBIRD DR., HILLSBORO,TEXAS 76645
DURISCH,LAWRENCE L. 34 ACT OTO
304 ENOTA DR., GAINESVILLE 30501
DURRENCE,LEONARD C.,JR. 72 ACT FP
BLACKSHEAR CLINIC, BLACKSHEAR 31516
DURRETT,DONALD M. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
DUTTERA,MAURICE J.,JR. 68 ACT I
303 SMITH ST., LAGRANGE 30240
DYCKMAN,EDWARD 29 ACT I
5632 WYSONG TR.,NE, DUNWOODY 30338
DYKEN,PAUL R. 54 ACT PDN
MED. COLLEGE OF GA., AUGUSTA 30902

DYNIN,MICHAELA 11 ACT P
P. O. BOX 13607, SAVANNAH 31406

E

EARLE,WALTER C. 22 DE5
2750 REDDING RD. NE, ATLANTA 30319
EARLEY,WILLIAM H. 34 A P
BOX 2395, GAINESVILLE 30501
EASLEY,CONRAD H. 76 ACT OR
1203 MEMORIAL DR., DALTON 30720
EASLEY,CURRAN S.,JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240
EASON,HARMER O.,JR. 79 ACT I
207 E. WILLINGHAM, SYLVESTER 31791
EATON,JAMES M.,JR. 47 ACT U
717 20TH ST., COLUMBUS 31904
EATON,S. BOYD 29 ACT R
265 IVY ST., NE, ATLANTA 30303
EAVES,ROBERT F.,JR. 22 ACT
2390 MAIN ST., TUCKER 30084
EBERHARDT,REESE C. 06 ACT FP
227 ORANGE ST., MACON 31201
EBERHART,CHARLES 29 DE1 U
1738 COUNCIL BLUFF DR., ATLANTA 30345
EBERSBACH,DAVID 17 ACT OR
2550 WINDY HILL RD, MARIETTA 30060
ECHEMENDIA,MARIANO M. 29 ACT OBG
384 PEACHTREE ST. NE, ATLANTA 30308
ECHOLS,GEORGE L.,JR. 54 ACT PD
1021 15TH ST., AUGUSTA 30901
ECHOLS,JOSEPH M. 54 ACT OBG
1430 HARPER S ., AUGUSTA 30902
EDENFIELD,R. W. 06 ACT SU
726 FIRST STREET, MACON 31201
EDGENS,JACK R. 27 ACT
RT. 5 HORSESHOE BEND, ROME 30161
EDMONDSON,H. T.,JR. 54 ACT SU
V. A. HOSPITAL, AUGUSTA 30904
EDMONDSON,STEPHEN W. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338
EDMONDSON,T. L. 66 ACT FP
TIFTON 31794
EDWARDS,A. JOSEPH,JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
EDWARDS,CHARLES H. 29 ACT
1000 JOHNSON FERRY RD.,NE, ATLANTA 30305
EDWARDS,ERNEST G.,JR. 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405
EDWARDS,F. KATHRYN 22 ACT R
4777 REBEL TRAIL NW, ATLANTA 30327
EDWARDS,FRANKLIN D. 47 ACT U
1430 3RD AVE., COLUMBUS 31901
EDWARDS,M. DELMAR 47 ACT SU
804 4TH AVE., COLUMBUS 31901
EDWARDS,PHILIP D. 22 ACT U
960 JOHNSON FERRY RD, #420, ATLANTA 30342
EDWARDS,WM. T.,JR. 29 ACT OPH
1218 W PACES FERRY RD. #104, ATLANTA 30327
EGAN,RICHARD W. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520
EGAN,ROBERT L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
EHIK,JULIUS 29 ACT P
811 JUNIPER ST. NE, ATLANTA 30308
EHLERS,JAMES A. 29 ACT I
6500 VERNON WOODS DR,NE,B12, ATLANTA 30328
EHRLICH,JONATHAN S. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD., ATLANTA 30342
EHRLICH,M.A. 21 DE5 PD
231 E. BROUGHTON ST., BAINBRIDGE 31717
EIDEX,MARSHALL F. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
EIDEX,MAXWELL A. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
EIDSON,RODGER H. 76 ACT OBG
MEDICAL ARTS BLDG., DALTON 30720
EITH,RONALD E. 22 ACT AL
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30341
ELDRIDGE,F. G. 56 DE5 R
2307 RIVERHILL DR., VALDOSTA 31601
ELKINS,JAMES A. 47 DE1 OR
P.O. BOX 5364, COLUMBUS 31906
ELLINGTON,PRESTON DAVID 54 ACT PD
824 WINDSOR CT., AUGUSTA 30904
ELLIOTT,C. B. 27 ACT SU
CEDARTOWN 30125
ELLIOTT,J. L. 11 DE5 I
212 E. HUNTINGDON ST., SAVANNAH 31401
ELLIOTT,RALPH A. 29 A I
STUD HEALTH SERV. GA TECH, ATLANTA 30308
ELLIS,JOHN O. 29 ACT R
384 PEACHTREE ST. NE, ATLANTA 30308
ELLIS,RALPH G.,JR. 54 ACT ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30904
ELLISON,LOIS T. 54 ACT
TALMADGE MEM. HOSP., AUGUSTA 30902
ELLISON,ROBERT G. 54 ACT TS
MED. COLLEGE OF GEORGIA, AUGUSTA 30904
ELLZEY,B. FRANK 22 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
ELLZEY,MILDRED JANE 22 ACT PD
5040 SNAPFINGER WOODS DR., DECATUR 30032
ELMER,R. A. 29 ACT R
6500 VERNON WOODS DR. NE, ATLANTA 30328
ELROD,BRUCE A. 70 ACT PATH
P.O. BOX 2042, FT. OGLETHORPE 30742
ELROD,DAN B. 01 ACT FP
PROFESSIONAL ARTS CTR., HAZLEHURST 31539
ELSAS,LOUIS J. 29 A PD
EMORY UNIV. SCHOOL OF MED., ATLANTA 30322
ELSEA,WILLIAM R. 29 ACT PH
99 BUTLER ST. SE, ATLANTA 30303
ELSON,EILEEN F. 29 DE1 PATH
78 SHERIDAN DR., NE #10, ATLANTA 30305
ELSON,SHIA H. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30345
ENCINAS, SENEN J. 39 ACT FP
P.O. BOX 151, LOUISVILLE 30434
ENGEL,M. F. 30 ACT D
3114 SHRINE RD., BRUNSWICK 31520
ENGELHARDT,SAMUEL M.,III 29 ACT OBG
710 PEACHTREE ST. NE, ATLANTA 30309
ENGLER,HAROLD S. 54 ACT SU
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
ENGLISH,INMAN C. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
ENSLEN,PHILLIP J. 71 ACT FP
247 ALCOVA ST., MONROE 30655
EPPS,GEORGE L. 47 R R
THE MEDICAL CENTER, COLUMBUS 31902
EPSTEIN,JACOB 29 ACT OBG
1175 PEACHTREE STREET NE, ATLANTA 30309
ERICKSON,PAUL T. 29 A PH
109 PARKWOOD LANE, DECATUR 30030
ERICSSON,JUDITH A. 29 ACT ANES
3372 LYNNRAY DR.,NE, ATLANTA 30340
ERKAN,N.V. 29 ACT PD
2730-B FELTON DR., EAST POINT 30344
ERKULVRAWATR,S. 54 ACT N

ERMUTLU,ILHAN M. 11 ACT P
P. O. BOX 119, COLUMBIA, SC 29202
ERWIN,GEORGE 15 ACT PD
1010 PRINCE AVENUE, ATHENS 30601
ERWIN,GOODLOE Y. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
ESENER,ISMAIL 27 ACT OBG
P.O. BOX 418, MT. BERRY 30149
ESPY, PAUL D. 17 ACT D
114 CHERRY ST., STE. E, MARIETTA 30060
ESPY,GOODMAN B.,III 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
ESTES,EDWARD E.,JR. 34 ACT U
290 ENOTA DRIVE NE, GAINESVILLE 30501
ESTES,J. W. 22 ACT VS
353 PARKWAY DR. NE, ATLANTA 30312
ESTES,RICHARD C. 29 ACT U
35 COLLIER RD. NW, ATLANTA 30309

ETHERIDGE,E. H. 03 ACT FP
WINDER 30680
ETHERIDGE,JAMES L. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
ETHERIDGE,JOHN G. 06 ACT PATH
BOX 6000, MACON 31208
EUBANKS,OMER L. 29 ACT I
1143 ALPHARETTA ST., ROSWELL 30075
EUBANKS,WM. L. 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
EVANS,ALBERT L. 29 ACT SU
735 PIEDMONT AVE. N. E., ATLANTA 30308
EVANS,DONALD C. 04 ACT FP
NEAMAR VILLAGE, CARTERSVILLE 30120
EVANS,E. C. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
EVANS,FRANK O.,JR 02 ACT I
511 N. COBB ST., MILLEDGEVILLE 31061
EVANS,J. RUFUS 22 DE5 FP
STONE MOUNTAIN 30083
EVANS,JAMES A. 47 ACT ANES
P.O. BOX 2748, COLUMBUS 31902
EVANS,JAMES P. 11 ACT PD
5102 PAULSEN ST., #3, SAVANNAH 31405
EVANS,WM. W. 29 DE1 I
450 ROCK SPRINGS RD. NE, ATLANTA 30324
EVERETT,THEODORE 54 ACT U
1467 HARPER ST., AUGUSTA 30902
EVERSOLE,JOSEPH W. 06 ACT PATH
P. O. BOX 6000, MACON 31208
EWING,R. B. 06 ACT D
781 SPRING STREET, MACON 31201
EYZAGUIRRE,WM. A. 29 ACT C
5064 NANDINA LANE, DUNWOODY 30338
EZZARD,GEORGE P. 13 ACT FP
CROGAN ST., LAWRENCEVILLE 30245

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FACKLER,WILLIAM B.,JR. 68 ACT I
LAGRANGE 30240
FADEL,HOSSAM E. 54 ACT OBG
DEPT OBG, MCG, AUGUSTA 30902
FADEL,SKINA H. 54 ACT ANES
MEDICAL COLLEGE OF GA.,ANES., AUGUSTA 30902
FAGIN,RONALD R. 11 ACT I
5102 PAULSEN ST., SAVANNAH 31405
FALBAUM,HARTLEY L. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792
FARMER,CHAS. W.,JR. 20 ACT OALR
P.O. BOX 160, NEWNAN 30263
FARRELL,ROBERT A. 27 ACT PATH
FLOYD COUNTY HOSP., ROME 30161
FARRIS,JOHN DUNCAN 72 ACT OBG
P. O. BOX 177, WAYCROSS 31501
FARRIS,JOHN J. 39 ACT
BARTOW 30413
FARROW,ROYAL T. 76 ACT PD
MEDICAL ARTS BLDG., STE E, DALTON 30720
FARUQUI,A. M. A. 29 A C
549 PEACHTREE ST., APT. 703, ATLANTA 30308
FAULKNER,ALVA H. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904
FAULKNER,ROBERT L. 48 ACT FP
1022 TATE ST., COVINGTON 30209
FEIGENBAUM,ERNEST 29 A PH
620 PEACHTREE ST.,NE, ATLANTA 30308
FEINERMAN,LOIS K. 17 ACT D
1680 MULKEY RD., AUSTELL 30001
FEINERMAN,MICHAEL B. 17 ACT PL
1680 MULKEY RD., AUSTELL 30001
FEINSMITH, LESLIE M. 16 ACT NE
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
FELDER,LOUIS H. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
FELDER,RICHARD E. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
FELDMAN, GARY E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
FELDMAN,DANIEL S. 54 ACT N
1120 15TH ST., AUGUSTA 30902
FELDMAN,ELAINE B. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
FELKER,FORT F.,JR. 76 ACT
216 N. PENTZ ST., DALTON 30720
FELLNER,DONALD W. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344
FELNER,JOEL M. 29 A C
GRADY MEM. HOSP., ATLANTA 30303
FERGUSON,IRA A.,JR. 29 A SU
EMORY UNIV. CLINIC, ATLANTA 30322
FERGUSON,WILSON J. 29 ACT SU
GENERAL MOTORS CORP., DORAVILLE 30340
FERNANDEZ,ANDRES P. 16 ACT FP
1660 BETHHAVEN RD., RIVERDALE 30274
FERNANDEZ,ANTONIO 06 ACT OR
870 HIGH ST., MACON 31201
FERNANDEZ,B. P. 42 ACT I
V. A. CENTER, DUBLIN 31021
FERNANDEZ,E. J. 07 ACT FP
SPRING ST., ELLIJAY 30540
FERNANDEZ,EZEQUIEL P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
FERNANDEZ,JOSE A. 65 ACT FP
1904 SW 22ND AVENUE, MIAMI, FL 33145
FERRELL,M. LYNN 47 ACT FP
325 E. BROAD ST., SPARTA 31087
FERRELL,R. G.,JR. 06 ACT SU
745 PINE STREET, MACON 31201
FERRELL,T. J.,JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501
FERRELL,WM. C. 34 ACT R
HALL CO. HOSPITAL, GAINESVILLE 30501
FERRIER,FRANK L. 17 ACT TS
754 CHEROKEE, MARIETTA 30060
FERRIS,HAROLD A. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308
FIEDOTIN,ARNOLDO 29 ACT I
265 IVY ST. NE, ATLANTA 30303
FIELD,DAVID E. 14 ACT FP
MEDICAL LANE, CANTON 30114
FIESELER, DAVID P. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
FILARDI,GERALD A. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
FILLINGIM,DAVID B. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401
FILLINGIM,DAVID W. 11 ACT OBG
1 ST. JOSEPH PROF. PLAZA, SAVANNAH 31406
FILLINGIM,JOHN M. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401
FILSON,EDGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
FINCH,CHARLES S.,JR. 17 ACT ANES
2550 WINDY HILL RD., MARIETTA 30061
FINCH,HENRY M. 29 ACT PR
490 PEACHTREE ST. N. E., ATLANTA 30308
FINCHER,RONALD E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
FINDLAY,PRENTISS E. 23 ACT PD
HOUSTON MED CTR BOX 20780, HOUSTON TX 77030
FINE,ROBT. M. 22 ACT D
755 COLUMBIA DR., DECATUR 30030
FINEGAN,ROBERT FRANKLIN 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
FINGER,ELLIOTT R. 11 ACT PL
38 MEDICAL ARTS CENTER, SAVANNAH 31405
FINNEY,C. E. 23 ACT OPH
521 THIRD AVE., ALBANY 31701
FINNEY,H. RAY 54 ACT U
1512 ANTHONY RD., AUGUSTA 30904
FISH,JOHN S. 29 ACT OB
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
FISHBACK,MALCOLM E. 54 ACT TS
1467 HARPER ST., AUGUSTA 30902
FISHBEIN,SUMNER 54 ACT OPH
1467 HARPER ST., AUGUSTA 30902
FISHER, GILBERT F.,JR 17 ACT OBG
592 CUPELO DR., MARIETTA 30060

FISHER,GEORGE B. 68 ACT
FRANKLIN 30217
FISHER,J. EDWARD 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
FISHER,WM. R. 29 ACT ALR
490 PEACHTREE ST. NE, ATLANTA 30308
FISHMAN,LEONARD 22 ACT D
2754 N. DECATUR RD., DECATUR 30030
FITE,J. DONALD 22 ACT OPH
542 CHURCH ST., DECATUR 30030
FITZGERALD,EDMUND M.,JR. 42 S I
VA CENTER, DUBLIN 31021
FITZHUGH,F. W.,JR. 29 ACT I
1938 PEACHTREE ROAD NW, ATLANTA 30309
FITZPATRICK,PAUL E. 29 ACT I
6185 JONESBORO RD., MORROW 30260
FIVEASH,ARLIE E. 54 ACT R
1467 HARPER ST., AUGUSTA 30902
FIX,RICHARD M. 30 ACT PD
2705 WILDWOOD DR., BRUNSWICK 31520
FLANAGAN,JAMES C. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
FLANAGAN,WM. C.,JR. 47 ACT OBG
P.O. BOX 157, COLUMBUS 31902
FLANAGIN,W. STEWART 54 ACT PL
1125 DRUID PARK AVE., AUGUSTA 30904
FLANDERS,CHARLES E.,JR. 17 ACT ANES
754 CHEROKEE ST. NE, MARIETTA 30060
FLEISHER,ALAN S. 29 ACT NS
1365 CLIFTON RD.,NE, ATLANTA 30322
FLEMING,LAMAR L. 29 ACT OR
1365 CLIFTON RD.,NE, ATLANTA 30322
FLEMING,SIDNEY H. 22 ACT P
1256 BRIARCLIFF RD. NE, ATLANTA 30306
FLEMING,WILLIAM H. 29 ACT TS
1365 CLIFTON RD. NE, ATLANTA 30322
FLESCH,W. L. 72 ACT U
P.O. BOX 2007, WAYCROSS 31501
FLETCHER,GERALD F. 29 A I
300 BOULEVARD NE, ATLANTA 30312
FLETCHER,MELVIN R. 17 ACT PD
122 CHERRY ST., MARIETTA 30060
FLINCHUM,DARIUS 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
FLINT,LUCIEN A. 14 ACT R
R. T. JONES MEM. HOSP., CANTON 30114
FLORENCE,LOREE 15 DE5 PD
P. O. BOX 682, ATHENS 30601
FLORENCE,THOMAS J. 29 ACT U
255 WINDY HILL ROAD, MARIETTA 30062
FLOURNOY,EDWIN E.,JR. 23 ACT FP
810 13TH AVE., ALBANY 31701
FLOURNOY,HENRY W. 30 ACT OBG
2444 PARKWOOD DR., BRUNSWICK 31520
FLOWERS,EUGENE MONROE 66 ACT FP
TIFTON 31794
FLOWERS,ROBERT M. 47 ACT PD
2039 WARM SPRINGS RD., COLUMBUS 31904
FLOWERS,THOMAS EDWARD 27 ACT OPH
103 JOHN MADDOX DR., ROME 30161
FLOYD,EARL H. 29 DE1 U
3705 VERMONT RD. NE, ATLANTA 30319
FLOYD,T. J.,JR. 59 ACT SU
506 S. 8TH ST., GRIFFIN 30223
FLOYD,WALDO E.,JR. 06 ACT OR
870 HIGH ST., MACON 31208
FLYNN,JAMES T.,JR. 19 ACT OALR
MOULTRIE 31768
FLYNN,THOMAS F. 60 DE4 SU
U. S. PHS. HOSP. 6500, NORFOLK, VA. 23508
FOKES,ERNEST C. 22 ACT NS
365 WINN WAY, DECATUR 30030
FOKES,ROBERT E.,JR. 19 ACT OALR
MOULTRIE 31768
FONTANA,NORVERTO A. 65 ACT FP
P. O. BOX 1867, THOMASVILLE 31792
FORBES,G. LESTER,JR. 29 ACT PATH
3200 HOWELL MILL RD,NW, ATLANTA 30327
FORBIS,SAMUEL E.,JR. 20 ACT R
P. O. BOX 997, NEWNAN 30263
FORD,HENRY J. 15 ACT P
1010 PRINCE AVE., ATHENS 30601
FORD,WILLIAM C. 28 ACT FP
BOX 5, LAVONIA 30553
FORESTER,B. W. 06 ACT I
618 ORANGE ST., MACON 31201
FORRESTER,EDWARD S.,JR. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
FORSHNER,JOHN G. 76 ACT D
1217 MEMORIAL DR., DALTON 30720
FORSYTH,DOUGLAS H. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
FORTSON,LUTHER G.,JR. 17 ACT I
KENNESTONE HOSP., MARIETTA 30060
FOSTER,CATHERINE E. 71 ACT OBG
924 W. SPRING ST., MONROE 30655
FOSTER,GURDON R.,JR. 59 ACT FP
MCDONOUGH 30253
FOSTER,H. R. 22 ACT PD
7660 COVINGTON HWY., LITHONIA 30058
FOSTER,HENRY A. 59 ACT
319 S. 9TH ST., GRIFFIN 30223
FOSTER,THOMAS V. 47 ACT P
1953 SEVENTH AVE., COLUMBUS 31904
FOUNTAIN,T. GRAY 23 ACT SU
910 N. JEFFERSON, ALBANY 31705
FOWLER,C. DIXON 29 ACT PD
27 EIGHTH ST. N. E., ATLANTA 30309
FOWLER,JOHN E. 60 ACT FP
P. O. BOX 825, CLAYTON 30525
FOWLER,MAJOR F. 29 DE5 U
620 PEACHTREE ST NE #505, ATLANTA 30308
FOWLER,MARK W. 23 ACT FP
1010 N. MADISON ST., ALBANY 31701
FOWLER,R. W.,JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060
FOX,BRENT 47 ACT OALR
MEDICAL ARTS BLDG., COLUMBUS 31901
FRANCH,ROBERT H. 29 ACT I
EMORY UNIV. CLINIC, ATLANTA 30322
FRANCK,GEORGE H. 29 ACT IND
64 PERIMETER CTR. EAST NE, ATLANTA 30346
FRANCO,JAIME 42 ACT PATH
LAURENS MEM. HOSP., DUBLIN 31021
FRANCO,NED M. 29 ACT U
960 JOHNSON FERRY RD. NE, ATLANTA 30342
FRANCO,RICHARD D. 29 ACT I
25 PRESCOTT ST., ATLANTA 30308
FRANK,MARTIN J. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
FRANK,MILTON,III 29 ACT I
1175 PEACHTREE ST. NE, ATLANTA 30309
FRANKLIN,ERNEST W. 29 ACT OBG
25 PRESCOTT ST. NE, ATLANTA 30308
FRASER,WHITMAN 62 ACT FP
FRASER DRIVE, HINESVILLE 31313
FRAZIER,WESLEY T. 29 ACT ANES
475 WOODRUFF MEMORIAL BLDG., ATLANTA 30322
FREANT,LAWRENCE J. 06 ACT C
726 FIRST ST., MACON 31201
FREDERICKSON,EVAN L. 29 ACT ANES
ANES. DEPT., EMORY UNIV., ATLANTA 30322
FREEDMAN,L. M. 11 ACT SU
803 EAST 70TH ST #105, SAVANNAH 31405
FREEDMAN,MILTON H. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312
FREEDMAN,MURRAY A. 54 ACT OBG
1621 PENDLETON ROAD, AUGUSTA 30904
FREEDMAN,SANDRA N. 54 ACT R
VA. HOSP., AUGUSTA 30904
FREEMAN,ATWOOD M.,JR. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701
FREEMAN,CHARLES 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
FREEMAN,JAMES C. 55 ACT FP
106 E. TELEPHONE ST., SYLVANIA 30467
FREEMAN,LAWRENCE C.,JR. 29 ACT ANES
355 LINDBERG DR. NE, ATLANTA 30305
FREEMAN,LAWRENCE L. 22 ACT
3652 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341

FREEMAN,MALCOLM G. 29 A OBG
463 KIRK RD., DECATUR 30030
FREEMAN,OLEN I. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338
FREEMAN,RONALD A. 06 ACT PL
380 HOSP. DR., MACON 31201
FREEMAN,THOMAS R. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401
FREGOSI,ALBERT H. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
FRENCH,JAMES B. 34 ACT OBG
1100 VINE ST., GAINESVILLE 30501
FREYRE,ROBERT C. 48 ACT FP
943 COURT ST., CONYERS 30207
FRIEDEWALD,WM. F. 29 ACT I
1293 PEACHTREE ST. NE, ATLANTA 30309
FRIEDRICH,ERIC W. 30 ACT OTO
2705 WILDWOOD DR., BRUNSWICK 31520
FRISTOE,JOHN W.,JR. 22 ACT OBG
1551 MASON MILL RD. NE, ATLANTA 30329
FROLICH,DAVID J. 06 ACT
752 HEMLOCK ST., MACON 31201
FROST,H. R. 25 ACT FP
SWAINSBORO 30401
FUERST,JULIAN F. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030
FULGHUM,C. B.,JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
FULLER,GEO. W. 29 DE5 FP
2638 PEACHTREE RD. NE, ATLANTA 30305
FULMER,THOMAS E. 29 ACT P
1711 AIDMORE DR. NE, ATLANTA 30307
FULMER,WM. HENRY 11 ACT FP
22 E. 34TH ST., SAVANNAH 31401
FUNDERBURG,FREDERICK D. 02 DE5
6005 HUGHES ST., SAN DIEGO, CAL 92115
FUNDERBURKE,A. G. 19 DE1 FP
1935-4TH ST. SE, MOULTRIE 31768
FUNK,F. JAMES,JR. 29 ACT OR
1938 PEACHTREE ROAD NW, ATLANTA 30309
FUNK,SIDNEY A. 29 ACT OBG
275 CARPENTER DR., ATLANTA 30329
FUNKHOUSER,W. L. 29 DE5 PD
47 PEACHTREE PARK DR. NE, ATLANTA 30309
FUSSELL,DANIEL O. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093
FUTCH,C. B. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520
FUTCH,WILLIAM A. 48 ACT FP
CONYERS 30207

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GABLE,THOMAS W. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
GABLER,REGINA 29 ACT OBG
950 W. PEACHTREE ST. N. W., ATLANTA 30309
GAFFORD,A. V. 27 ACT OPH
HARBIN CLINIC, ROME 30161
GALAMBOS,JOHN T. 29 ACT I
69 BUTLER ST. SW, ATLANTA 30303
GALEN,NORMAN R. 47 DE4 U
MARTIN ARMY HOSP., FT BENNING 31905
GALEN,WESLEY K. 47 ACT D

GALIN,A. N. 30 DE1 FP
P.O. BOX 1055, ST. SIMONS IS. 31522
GALL, HENRY, 65 DE5 FP
P.O. BOX 502, CAIRO 31728
GALLEMORE,J. L. 06 ACT FP
PERRY 31069
GALLER,EDWIN J. 22 ACT I
2054-G LAWRENCEVILLE HWY, DECATUR 30033
GALLIS,ANTHONY H. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
GALLOSTRA,JUAN A. 17 ACT I
2751 HAMMONDTON RD #D-8, MARIETTA 30060
GALLOWAY,BENJAMIN THOMAS 30 ACT SU
3010 HAMPTON, BRUNSWICK 31520
GALLOWAY,LOUISE J. 30 ACT ANES
2850 WILDWOOD DR., BRUNSWICK 31520
GALLOWAY,RONALD FROST 54 ACT TS
1467 HARPER ST., AUGUSTA 30902
GALLOWAY,WM. H. 29 ACT OBG
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
GALVIN,WM. H. 29 ACT ANES
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
GAMBRELL,W. ELIZABETH 29 DE5 I
384 PEACHTREE ST. N. E., ATLANTA 30308
GAMMAL,T. A. EL 54 ACT NR
MED. COLLEGE OF GA., AUGUSTA 30902
GAMWELL,JOHN W. 29 ACT OR
25 PRESCOTT ST. NE, ATLANTA 30308
GANN,JOYCE A. 22 ACT OBG
365 WINN WAY, DECATUR 30030
GARCIA-RIVERA, CARLOS 02 ACT FP
CENTRAL STATE HOSPITAL, MILLEDGEVILE 31061
GARCIA,BENITO 02 ACT FP
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
GARCIA,J. BERNARDO 02 DE2 ANES
MED. COLLEGE OF GA., AUGUSTA 30902
GARCIA,P. F. 29 ACT P
3316 PIEDMONT RD NE, ATLANTA 30305
GARCIA,RUBEN E. 15 ACT FP
1010 PRINCE AVE., ATHENS 30601
GARDNER,JOSEPH M. 17 ACT OBG
2404 AUSTELL MARIETTA RD., AUSTELL 30001
GARDNER,NORMAN P. 69 ACT FP
101 AVENUE F, THOMASTON 30286
GARFIELD,HERBERT I. 16 ACT PD
217 ARROWHEAD BLVD., JONESBORO 30236
GARLAND,JOHN W.,III 34 ACT P
500 E. SPRING ST., GAINESVILLE 30501
GARNER,CYLER D. 06 ACT
GORDON MEDICAL CENTER, GORDON 31031
GARNER,W. R. 34 DE5 I
RT. 12, BOX 163-1, GAINESVILLE 30501
GARNETT,ROBERT L. 47 ACT R

GARRETT,LUKE G.,JR. 17 ACT
AUSTELL 30001
GARRETT,ROBERT C. 26 ACT FP
412 CHURCH ST., VIENNA 31092
GARRISON,ALTON F. 54 ACT SU
3623 J DEWEY GRAY CIR., AUGUSTA 30904
GARRISON,D. H. 33 DE5 FP
CLARKESVILLE 30523
GARRISON,FLETCHER O. 33 ACT FP
912 WAYSIDE ST., CORNELIA 30531
GARRISON,GLEN E. 54 ACT C
MED. COLLEGE OF GA., AUGUSTA 30902
GARRISON,JOSEPH MAYES 54 ACT ANES
812 13TH ST., AUGUSTA 30901
GATES,EDWARD M. 27 ACT NS
HARBIN CLINIC, ROME 30161
GATEWOOD,T. SCHLEY 61 ACT OBG
205 SOUTH LEE STREET, AMERICUS 31709
GAUTHIER,P. D. 06 ACT FP
JEFFERSONVILLE 31044
GAY,BRIT B.,JR. 29 ACT R
1405 CLIFTON RD. NE, ATLANTA 30333
GAY,FRANCIS M. 19 ACT FP
MOULTRIE 31768
GAY,THOMAS BOLLING 29 DE1 PD
3042 W. PINE VALLEY RD. N.W., ATLANTA 30305
GECKLER,JOHN H. 29 ACT ANES
20 LINDEN AVE. NE, ATLANTA 30308
GEDNEY,LEIGH M. 29 S U
818 FED ANNEX, ATLANTA 30304
GEE,W. N.,JR. 56 ACT I
401 E. JANE ST., VALDOSTA 31601
GEER,BRUCE R. 29 ACT GE
3250 HOWELL MILL RD NW #200, ATLANTA 30327
GEERKEN,LUIS A. 20 ACT ANES
COWETA GENERAL HOSPITAL, NEWNAN 30263
GEESLIN,JAMES M. 14 ACT SU
110 WALESKA RD., CANTON 30114
GEIGER,C. LEONARD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501

GENT,JACK 76 ACT SU
P.O. BOX 1969, DALTON 30720
GEORGE,WILLIAM M.,JR. 23 ACT OBG
907 JEFFERSON ST., ALBANY 31707
GERMAIN,A. H. 29 DE5 FP
259 ARROWHEAD BLVD., JONESBORO 30236
GERMAN,THOMAS L. 11 ACT OR
210 HALL ST. EAST, SAVANNAH 31401
GERSHON,NATHAN I. 29 ACT OALR
340 BOULEVARD NE, ATLANTA 30312
GERSON,GORDON N. 17 ACT OR
1620 MULKEY RD., AUSTELL 30001
GERTLER,PHILLIP E. 29 ACT I
1938 PEACHTREE RD. NW, ATLANTA 30309
GERTNER,HAROLD R.,JR. 29 ACT SU
35 COLLIER RD,NW,675, ATLANTA 30309
GHANI,CHARLES A. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
GHENT,OLIVER T. 34 R R
HALL CO. HOSP., GAINESVILLE 30501
GHOLSON,A. R. 29 ACT ANES
180 LAUREL FOREST CIR. NE, ATLANTA 30305
GIBBON,JOHN 27 ACT P
NW GA. REGIONAL HOSPITAL, ROME 30161
GIBBS,R. I.,JR. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033
GIBSON,FRANK L. 21 ACT SU
BAINBRIDGE 31717
GIBSON,HUGH H. 06 ACT OBG
380 HOSP. DR., MACON 31201
GIBSON,SAM T. 29 A
FDA, BLDG 29, RM 118, BETHESDA, MD 20014
GIBSON,WALLACE M. 49 ACT
106 N. JEFFERSON ST., EATONTON 31024
GIDDENS,I. S. 56 ACT FP
LAKELAND 31635
GIDDENS,RICHARD D. 76 ACT SU
MEDICAL ARTS BLDG., DALTON 30720
GILBERT,BEN P. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
GILBERT,CARL N. 76 ACT PD
MEDICAL ARTS BLDG., DALTON 30720
GILBERT,CHARLES A. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
GILBERT,CLYDE D. 60 ACT OBG
800 E. DOYLE ST., TOCCOA 30577
GILBERT,FREDERICK E. 20 ACT PATH
COWETA GENERAL HOSP., NEWNAN 30263
GILBERT,PETER G. 27 ACT U
HARBIN CLINIC, ROME 30161
GILBERT,STEWART D. 66 ACT R
TIFT GENERAL HOSP., R TIFTON 31794
GILBERT,WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161
GILES,BEN J. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
GILES,EUGENE H. 58 ACT FP
322 S. MAIN ST., BLAKELY 31723
GILLESPIE,CHARLES B. 23 ACT OR
810 14TH AVE., ALBANY 31701
GILLESPIE,EUGENE J. 29 A D
47 TRINITY AVE. SW, ATLANTA 30334
GILLESPIE,JOE I. 54 ACT ALR
1511 ANTHONY RD., AUGUSTA 30904
GILLESPIE,ROBERT H. 29 ACT OBG
1938 PEACHTREE RD. NW, ATLANTA 30309
GILLETT,BRUCE M. 17 ACT N
50 PLAZA WAY, MARIETTA 30060
GILLIAM,O. D. 47 DE5 SU
P. O. BOX 2016, COLUMBUS 31902
GILLIARD,FRED E. 18 ACT FP
WARD ST., DOUGLAS 31533
GILLIKIN,WILLIAM V.,P.C 25 ACT FP
TWIN CITY 30471
GILMORE,THOMAS W.,JR. 74 ACT I
P. O. BOX 190, SANDERSVILLE 31082
GILNER,DONALD M. 29 ACT AL
960 JOHNSON FERRY RD., ATLANTA 30342
GINDIN,R. ARTHUR 54 ACT NS
TALMADGE MEM. HOSP., AUGUSTA 30902
GINSBERG,STEWART T. 29 R P
GIRARDEAU,HERBERT S.,JR 22 ACT SU
1270 MCCONNELL DR., DECATUR 30033
GIRARDEAU,JOSEPH L. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
GIRO,ERNESTO J. 02 ACT P
P.O. BO X 563, HARDWICK 31034
GLADSON,JAMES E. 29 ACT I
37 WILLOWICK CT., DECATUR 30034
GLASSMAN,ARMAND B. 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902
GLAZEBROOK,GEORGE W. 14 ACT SU
110 WALESKA ROAD, CANTON 30114
GLENN,FRANK D. 08 I&R U
510 GENTILLY ROAD, STATESBORO 30458
GLENN,T. LAMAR 15 ACT I
740 PRINCE AVE., ATHENS 30601
GLENN,WADLEY R. 29 ACT SU
35 LINDEN AVE. N. E., ATLANTA 30308
GLISSON,C. STEADMAN 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
GLOVER,D. H. G. 54 ACT PH
2100 MCDOWELL ST., AUGUSTA 30904
GLOVER,DOUGLAS D. 17 ACT OBG
653 CHEROKEE ST. NE, MARIETTA 30060
GLOVER,HOWARD C.,JR. 20 ACT PD
NEWNAN 30263
GLOVER,N. B. 20 ACT PD
NEWNAN 30263
GLOVER,RIDLEY M. 42 ACT R
LAURENS MEM. HOSP., DUBLIN 31021
GLUCKMAN, RICHARD 17 ACT N
1680 MULKEY RD., AUSTELL 30001
GLUCKSMAN,MICHEL A. 30 ACT U
2705 WILDWOOD DR., BRUNSWICK 31520
GODWIN,JOHN THOMAS 29 ACT PATH
265 IVY STREET NE, ATLANTA 30303
GOICOECHEA,PILAR 02 ACT R
P.O. BOX 507, HARDWICK 31034
GOLD,HOMER LECIL,JR. 14 ACT FP
110 WALESKA ST., CANTON 30114
GOLD,PERRY 29 A PD
2795 MRGRT MITCHELL DR. NW, ATL. 30327
GOLDEN,HOWARD A. 29 ACT OBG
970 HUNTER ST. SW, ATLANTA 30314
GOLDENSTAR,G. W. 11 ACT OPH
26 MEDICAL ARTS CENTER, SAVANNAH 31405
GOLDIN,HAROLD W. 27 ACT FP
ROCKMART 30153
GOLDMAN,GILBERT C. 29 ACT D
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
GOLDMAN,JOHN A. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
GOLDMAN,KENNETH L. 47 ACT SU
905 CENTER ST., COLUMBUS 31901
GOLDMAN,MILTON S. 29 ACT U
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GOLDMAN,NORMAN I. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
GOLDSMITH,ABRAM O. 23 ACT OBG
P.O. BOX 714, ALBANY 31702
GOLDSMITH,HOWARD G. 47 ACT OR
2009 WARM SPRINGS RD., COLUMBUS 31901
GOLDSTEIN,GORDON T. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
GOLDSTEIN,MARTIN I. 17 ACT D
3001 S. COBB DR. SE, SMYRNA 30080
GOLDWASSER,FRED E. 72 ACT FP
ALMA 31510
GOLSAN,WILLARD R. 06 DE5 U
417 AMERICAN FEDERAL BLDG., MACON 31201
GOMEZ,FRANK 29 ACT SU
ARROWHEAD MEDICAL PLAZA, JONESBORO 30236
GOMEZ,JULIAN R. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
GOMEZ,MIGUEL R. 16 ACT ANES
409 ARROWHEAD BLVD, BLDG A, JONESBORO 30236
GOMEZ,ROBERT F. 15 ACT OTO
740 PRINCE AVE., ATHENS 30601

GONGAWARE,ROBERT D. 11 ACT SU
200 E. 31ST ST., SAVANNAH 31401
GONGAWARE,THEODORA L. 11 ACT I
P.O. BOX 6688, STA. C, SAVANNAH 31405
GONZALEZ,EVANGELIO 10 ACT FP
611 N. AVENUE, VILLA RICA 30180
GONZALEZ,FRANCISCO E. 14 ACT OBG
P.O. BOX 311, CANTON 30114
GONZALEZ,JOSE M. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
GONZALEZ,PABLO E. 29 ACT
4508 CHERIE GLEN TRAIL, ST. MT. 30083
GONZALEZ,VICTOR R. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GOODRICH,SAMUEL M. 02 ACT OBG
P.O. BOX 489, MILLEDGEVILLE 31061
GOODWIN,BURTON D.,JR. 11 ACT R
P. O. BOX 6688, SAVANNAH 31401
GOODWIN,FRANKLIN H. 42 S I
V A CENTER, DUBLIN 31021
GOODWIN,H. A.,JR. 27 ACT FP
SUMMERVILLE 30747
GOODWIN,HENRY N. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904
GOODWIN,T. W. 54 DE1 SU
1 INDIAN COVE, AUGUSTA 30904
GOOLSBY,SARA L. 70 ACT
211 ANDREWS ST., ROSSVILLE 30741
GORDON,JAMES H. 57 S PH
TOOMBS COUNTY HEALTH DEPT., LYONS 30436
GORDON,STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GORDON,WALTER C. 23 ACT SU
413 S. MADISON ST., ALBANY 31701
GOROD,HERBERT 17 ACT P
3188 ATLANTA ST.,SE, SMYRNA 30080
GOSS,CHRISTOPHER C. 26 ACT FP
ASHBURN 31714
GOSS,WOODROW 26 ACT FP
ASHBURN 31714
GOTTSCHALK,ROBERT BRUCE 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31401
GOULD,MARK A. 17 ACT P
3188 ATLANTA ROAD, SMYRNA 30080
GOWDER,GEORGE D.,JR. 34 ACT
P. O. BOX 726, BLAIRSVILLE 30512
GOWEN,JAMES F. 30 ACT OBG
2444 PARKWOOD DR., BRUNSWICK 31520
GOWER,W. J. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286
GRABLOWSKY,OSCAR M. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
GRACE,KENNETH D. 68 ACT SU
206 CHURCH ST., LAGRANGE 30240
GRACIAA,GUIDO F. 02 ACT N
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
GRADY,CHARLOTTE 29 ACT

GRADY,DONALD F. 29 ACT NS
1175 PEACHTREE ST. NE, ATLANTA 30309
GRADY,EDGAR D. 29 ACT
2788 BAYARD ST., EAST POINT 30344
GRAFFAGNINO,P. C. 47 ACT OBG
MEDICAL ARTS BLDG., COLUMBUS 31901
GRAHAM,HAMLIN 54 ACT OR
1021 15TH ST., AUGUSTA 30901
GRAHAM,THOMAS C. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263
GRAHAM,WILLIAM L. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31901
GRAHAM,WISTAR L. 17 ACT NS
86 S. COBB DR., MARIETTA 30063
GRAMLING,Z. W. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902
GRANT,EDWIN H. 10 ACT R
TANNER MEMORIAL HOSP., CARROLLTON 30117
GRANT,JOHN R. 23 ACT OTO
804 14TH AVE., ALBANY 31705
GRANT,LARRY W 06 ACT I
380 HOSPITAL DR.,460, MACON 31201
GRANT,R. PERRY 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GRANT,ROBERT 34 ACT OBG
174 PRIOR ST.,NE, GAINESVILLE 30501
GRANT,ROBERT W. 11 I&R I
BOX 6688, STA C, SAVANNAH 31405
GRANTHAM,C. G. 06 ACT ANES
P. O. BOX 352, GRAY 31032
GRANTHAM,V. J. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030
GRANTIER,DAVID R. 17 ACT FP
COBB GENERAL HOSP., AUSTELL 30001
GRAVANIS,MICHAEL B. 29 ACT PATH
703 WOODRUFF BLDG EMORY UNIV, ATLANTA 30322
GRAVES,EDWARD M. 60 ACT
MEDICAL ARTS BLDG., TOCCOA 30577
GRAVES,RAPHAEL K. 29 ACT PATH
1000 JOHNSON FERRY RD. NE, ATLANTA 30345
GRAY,ARTHUR R. 27 ACT SU
310 W. SIXTH ST., ROME 30161
GRAY,J. D. 54 DE5 I
J. DEWEY GRAY CIRCLE, AUGUSTA 30904
GRAY,JAMES R. 22 A PD
69 BUTLER ST. SE, ATLANTA 30303
GRAYDON,E. LEONARD 29 DE5 FP
101 3RD ST. NE, ATLANTA 30308
GRAYSON,JOHN T. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
GREEN,ALFRED JOSEPH 54 ACT PD
1727 CENTRAL AVENUE, AUGUSTA 30904
GREEN,BRUCE G. 29 ACT U
6500 VERNON WOODS DR.,NE, ATLANTA 30328
GREEN,CHARLES G. 09 ACT FP
223 EAST 6TH ST., WAYNESBORO 30830
GREEN,DONARELL R.,JR. 15 A FP

GREEN,EDMOND W. 29 ACT FP
3395 STEWART AVE., HAPEVILLE 30354
GREEN,GEORGE F. 49 ACT FP
325 E. BROAD ST., SPARTA 31087
GREEN,JAMES A. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
GREEN,JAMES FRANKLIN 10 ACT FP
POWELL CLINIC, VILLA RICA 30180
GREEN,RICHARD L. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30060
GREENBERG,IRVING L. 29 ACT SU
950 W. PEACHTREE ST. N. W., ATLANTA 30309
GREENBERG,JOEL I. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
GREENBLATT,ROBERT B. 54 ACT OBG
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
GREENE, RALPH R. 70 ACT FP
P.O. BOX 460, RINGGOLD 30736
GREENWALD,HERBERT S.,JR 06 ACT OPH
380 HOSPITAL DR., MACON 31201
GREER,CHARLES C. 26 ACT OPH
BOX 1115, CORDELE 31015
GREER,MACK V. 56 ACT FP
P. O. BOX 146, HOMERVILLE 31634
GREGOROFF,STANLEY 29 ACT I
384 PEACHTREE ST. NE, ATLANTA 30308
GREGORY,HUGH H. 29 ACT SU
735 PIEDMONT AVE. NE, ATLANTA 30308
GREGORY,JAMES R. 76 ACT OBG
MEDICAL ARTS BLDG., DALTON 30720
GRESHAM,WALTER S. 10 ACT
BOWDEN 30108
GRIFFETH,JOE L. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529
GRIFFIN,BASIL M.,JR. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GRIFFIN,JACK T. 47 ACT NS
2009 WARM SPRINGS RD., COLUMBUS 31904
GRIFFIN,JOHN B.,JR. 22 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
GRIFFIN,JOHN M. 29 ACT PL
3280 HOWELL MILL RD NE #111, ATLANTA 30327
GRIFFIN,JOSEPH W.,JR 54 ACT I
VA HOSP,FHD, AUGUSTA 30904

GRIFFIN,LOUIE H.,JR. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902
GRIFFIN,RICHARD A.,III 04 ACT SU
P. O. BOX 764, CARTERSVILLE 30120
GRIFFIN,WARREN L.,JR. 06 ACT OTO
800 FIRST ST., MACON 31201
GRIMES,W. H.,JR. 29 ACT OB
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
GRINER,WALLACE 47 ACT
5740 WILTSHIRE DR., COLUMBUS 31907
GRISAMORE,J. M. 29 ACT SU
6500 VERNON WOODS RD. NE, ATLANTA 30328
GROSS,PETER R. 29 ACT I
384 PEACHTREE ST. NE, ATLANTA 30308
GROSSMAN,CONRAD P. 06 ACT OBG
380 HOSP. DR., MACON 31201
GROSSMAN,GILBERT D. 29 ACT I
25 PRESCOTT ST. NE, ATLANTA 30308
GROVES,ROBERT H. 23 ACT FP
1100 N. MADISON ST., ALBANY 31701
GROW,WILLIAM R. 56 ACT I
311 WOODROW WILSON DR., VALDOSTA 31601
GUDE,A. V. 29 ACT ANES
3464 PINESTREAM RD. NW, ATLANTA 30327
GUERRY,RODERICK L. 11 ACT PATH
BOX 9787, SAVANNAH 31402
GUFFIN,THOMAS N. 29 ACT SU
461 KING ARNOLD ST., HAPEVILLE 30354
GUILLEBEAU,F. DEMPSEY 23 ACT I
P. O. BOX 288, ALBANY 31702
GULLEN,WARREN H. 54 ACT E
MED. COLLEGE OF GA., AUGUSTA 30902
GUNTER,OLIVER L. 46 ACT FP
34 PERRY ST., CAMILLA 31730
GURSEL,SEZAI 11 ACT PATH
P.O. BOX 9787, SAVANNAH 31402
GUSSACK,HAROLD A. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308
GUTIERREZ,RAFAEL 15 ACT P
296 PRINCE AVE., ATHENS 30601
GUY,J. CANDLER 29 ACT U
1938 PTREE RD, NW, STE. 206, ATLANTA 30309
GUZZARDI,LAWRENCE J. 11 ACT EM
11705 MERCY BLVD., SAVANNAH 31406

H

HAAK,EDWARD DECKER 45 ACT PM
1030 E. SAMFORD AVENUE, AUBURN, ALA 36830
HAAR,FLOYD L. 54 ACT NS
TALMADGE MEM. HOSP., AUGUSTA 30902
HAAS,MELVYN L. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30904
HABERMAN,GEORGE G. 11 ACT SU
P. O. BOX 9787, SAVANNAH 31402
HABERMAN,MICHAEL A. 29 A P
1177 ZIMMER DR.,NE, ATLANTA 30306
HACKER,MORTIMER 29 ACT PATH
1330 W. PTREE ST. NW, ATLANTA 30309
HACKNEY,J. F. 29 DE1 PH
1611 MILL ACRES DR. SW, ATLANTA 30311
HADAWAY,PHIL L. 11 ACT FP
716 E. 71ST ST., SAVANNAH 31405
HADDAD,LESTER M. 11 ACT EM
P.O. BOX 6688, STA. C, SAVANNAH 31405
HADLEY,ELIZABETH 16 ACT R
33 UPPER RIVERDALE RD #105, RIVERDALE 30274
HAEBERLE,MARK G. 27 ACT OBG
UNIV. KY MEDICAL CTR, LEXINGTON, KY 40504
HAGEN,ARTHUR R. 30 ACT OR
3010 HAMPTON AVE., BRUNSWICK 31522
HAGLER,WILLIAM S. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
HAGOOD,M. M. 17 ACT SU
50 PLAZA WAY, MARIETTA 30060
HAGOOD,MURL F. 17 ACT SU
660 CHEROKEE ST., MARIETTA 30060
HAGOOD,RICHARD M. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
HAHN,EDWARD E. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406
HAILEY,CHENAULT W. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308
HAJOSY,ELAINE L. 27 ACT ANES
P. O. BOX 27, ROME 30161
HAJOSY,LOUIS S.,JR. 27 ACT ANES
FLOYD HOSPITAL, ROME 30161
HAJOSY,RALPH W. 59 ACT OR
815 S. 8TH ST., GRIFFIN 30223
HALL,GEORGE W. 17 ACT R
3950 AUSTELL RD., AUSTELL 30001
HALL,HENRY L. 29 ACT P
EMORY UNIVERSITY, ATLANTA 30322
HALL,JESSE DENNY,JR. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
HALL,JOHN C. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
HALL,MAXWELL F.,JR. 17 ACT R
70 TOWER RD., MARIETTA 30060
HALL,W. D. 31 ACT SU
S. WALL ST., CALHOUN 30701
HALLMAN,B. L. 29 ACT I
69 BUTLER ST,SE, ATLANTA 30303
HALLMAN,HELEN W. 29 ACT ANES
159 FORREST AVE. NE, ATLANTA 30303
HALLUM,ALTON V. 29 DE5 OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
HALLUM,ALTON V.,JR. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
HALTIWANGER,EARL 29 S U
1670 CLAIRMONT RD. NE, ATLANTA 30329
HAM,OSCAR EMERSON 11 ACT PD
835 E. 65TH ST., SAVANNAH 31405
HAMES,CURTIS G. 08 ACT I
CLAXTON 30417
HAMFF,LEONARD H. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308
HAMILTON,NEWELL M. 30 ACT PD
2001 GLOUCESTER ST., BRUNSWICK 31520
HAMILTON,SANDRA D. 15 ACT ANES
165 DUNWOODY DR., ATHENS 30601
HAMILTON,THOMAS E. 13 ACT FP
1106 DULUTH HWY,. NW, LAWRENCEVILLE 30245
HAMILTON,VIRGINIA D. 04 A PH
BOX 1196, ROME 30161
HAMM,WM. G. 29 DE5 PL
3280 HOWELL MILL RD.,NW, ATLANTA 30327
HAMMETT,H. HILT,JR. 68 ACT OALR
HAMMETT BLDG., LAGRANGE 30240
HAMMONDS,RICHARD LEE 17 ACT FP
AUSTELL 30001
HAMMONDS,WILLIAM D. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
HANBERRY,RICHARD L. 06 ACT OBG
657 HEMLOCK STREET, MACON 31201
HANCOCK,CARL V.,JR. 23 ACT U
810-13TH AVE., ALBANY 31701
HANCOCK,CHARLES I. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
HANCOCK,ROBERT K. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
HANCOCK,S. L. 65 DE1
2ND AVE. SE, CAIRO 31728
HANES,O. EUGENE 29 ACT I
600 W. PEACHTREE ST. N. E., ATLANTA 30308
HANKEY,DANIEL D. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
HANKS,JACK B. 12 ACT FP
33 CHESTNUT STREET, ELBERTON 30635
HANNA,MICHAEL B. 20 ACT OPH
85 ACKSON ST., NEWNAN 30263
HANNAH,JAMES F. 15 ACT EM
435 PONDEROSA DR., ATHENS 30601
HANNER,JAMES P. 29 DE5 PD
49-26TH ST. NE, ATLANTA 30309
HANSEN,RICHARD A. 70 ACT FP
WILDWOOD HOSP., WILDWOOD 30757
HANSEN,ROBERT F. 29 S PH
2 EMMA LN. NE, ATLANTA 30305

HANSON,I. R.,JR. 17 A R
30 COLLIER RD,APT 8, ATLANTA 30309
HANSON,J. FLETCHER 06 DE5 I
3834 THE PRADO, MACON 31204
HANSON,THOMAS A. 54 ACT PD
DOCTORS HOSP. MED. PLAZA, AUGUSTA 30904
HARASZTI,ALEXANDER 29 ACT SU
217 ARROWHEAD BLVD., JONESBORO 30236
HARASZTI,ROSALIE 29 ACT FP
217 ARROWHEAD BLVD., JONESBORO 30236
HARBIN, THOMAS S.,JR 29 ACT OPH
2004 PEACHTREE RD.,NW, ATLANTA 30309
HARBIN,BANNESTER L.,JR. 27 ACT SU
HARBIN CLINIC, ROME 30161
HARBIN,LESTER 27 ACT SU
HARBIN CLINIC, ROME 30161
HARBIN,R. M.,JR. 27 DE5 SU
19 HORSELEG CREEK RD., ROME 30161
HARBIN,THOMAS S. 27 ACT OPH
HARBIN CLINIC, ROME 30161
HARBIN,W. P.,JR. 27 ACT I
HARBIN CLINIC, ROME 30161
HARBOUR,JOHN H. 17 ACT I
P. O. BOX 1266, SMYRNA 30080
HARDCASTLE,WILLIAM R. 22 ACT SU
9 LAVISTA PERIMETER OFC. PK., TUCKER 30084
HARDEMAN,FRANK 11 ACT EM
DE RENNE APTS., SAVANNAH 31401
HARDEN,TIMOTHY,JR. 22 ACT I
711 CHURCH STREET, DECATUR 30030
HARDEN,W. E. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520
HARDIN,FREDERICK F. 29 ACT D
1938 PEACHTREE RD. NW, ATLANTA 30309
HARDMAN,BILLY S. 34 ACT OBG
420 BROAD ST.,SE, GAINESVILLE 30501
HARDMAN,JOHN B. 29 ACT P
1938 P'TREE RD,NW,STE 505, ATLANTA 30309
HARDMAN,WILLIAM J. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
HARDY,WALLACE E. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084
HARLEY,EUGENE L. 17 ACT I
P.O. BOX 1266, SMYRNA 30080
HARLIN,JOYCE A. 29 A R
80 BUTLER ST. SE, ATLANTA 30303
HARPER, MEREDITH 18 ACT OBG
1001 W. WARD ST., DOUGLAS 31533
HARPER,BYRON F.,JR. 29 ACT I
2741 BAYARD ST., EAST POINT 30344
HARPER,CHARLES R. 29 ACT AM
P. O. BOX 20787, ATLANTA 30320
HARPER,CLARENCE H. 24 ACT
503 3RD ST., FOLKSTON 31539
HARPER,HARRY T.,III 54 ACT C
1467 HARPER ST., AUGUSTA 30902
HARPER,HARRY T.,JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
HARPER,HENRY W.,JR. 06 ACT ANES
742 CAPTAIN KELL DR., MACON 31204
HARPER,HERBERT S. 54 ACT PD
996 CAMPBLLTN RD., N. AUGUSTA, S. C. 29841
HARPER,WILLIAM FERRELL 23 ACT SU
810-13TH AVE., ALBANY 31701
HARPER,WILLIAM N. 29 ACT FP
75 PIEDMONT AVE. NE, ATLANTA 30303
HARREL,JOHN A.,JR 22 ACT AD
2701 N. DECATUR RD., DECATUR 30033
HARRELL,E. L. 75 ACT
RT. 4,BOX 424, JESUP 31545
HARRELL,H. P. 54 DE1 PD
1011 MARSHALL AVE., N. AUGUSTA, SC 29841
HARRIS,BOAZ 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
HARRIS,J. FRANK 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308
HARRIS,J. HENRY WALKER 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
HARRIS,JAMES B. 29 ACT OBG
1478 MOZLEY DR. SW, ATLANTA 30314
HARRIS,JOHN A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
HARRIS,STERLING A. 13 ACT
DOCTORS BUILDING, BUFORD 30518
HARRIS,T. A. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
HARRIS,WESLEY W. 28 ACT FP
ROYSTON 30662
HARRISON,CHARLES E.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HARRISON,CLYDE C.,JR. 16 ACT
1019 ASTOR AVE., FOREST PARK 30050
HARRISON,EUGENE O. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
HARRISON,F. N. 54 ACT OBG
1021 15TH ST., AUGUSTA 30901
HARRISON,GEORGE I. 17 ACT ALR
1416 CHEROKEE ST., MARIETTA 30062
HARRISON,JACOB R.,JR 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720
HARRISON,JAMES HAROLD 29 ACT
490 PEACHTREE ST. N. E., ATLANTA 30308
HARRISON,JOHN R. 22 ACT
5372 PEACHTREE RD., CHAMBLEE 30341
HARRISON,WALTER E. 19 ACT FP
711 S. MAIN, MOULTRIE 31768
HARTLAGE,PATRICIA L. 54 ACT OR
MED. COLLEGE OF GA., AUGUSTA 30902
HARTLEY,JOHN H.,JR. 29 ACT PL
3280 HOWELL MILL RD NW #111, ATLANTA 30327
HARTLEY,S. T. 16 ACT EM
4614 WINTHROP DR., COLLEGE PK. 30337
HARTMANN,HARRY R. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
HARTRAMPF,CARL R. 29 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
HARVEY,DAVID N.,III 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
HARVEY,LOUIS R. 19 A PH
P. O. BOX 383, SANDERSVILLE 31082
HARWELL,C. W. 19 A PH
561 CANDLEWOOD DR., ST. MOUNTAIN 30083
HASTINGS,E. V. 54 ACT PATH
ST. JOSEPHS HOSPITAL, AUGUSTA 30904
HASTON,HUGH B.,JR. 15 ACT OR
125 KING AVE., ATHENS 30601
HASTY,LEWIS B. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
HATCHER,CHARLES R. 29 ACT TS
EMORY CLINIC, ATLANTA 30322
HATCHER,MILFORD B. 06 ACT SU
781 SPRING ST., MACON 31201
HATFIELD,HUGH A. 22 ACT FP
2064 P'TREE INDUSTRIAL CT., CHAMBLEE 30341
HATHCOCK,WM. C. 29 ACT OALR
401 PEACHTREE ST. NE, ATLANTA 30308
HATIPOGLU,V.B. 10 ACT I
819 DIXIE STREET, CARROLLTON 30117
HATTAWAY,JAMES R. 23 ACT U
810-13TH AVE., ALBANY 31701
HAUCK,A. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
HAUGEN,HARRY T. 29 ACT FP
2391 SEWELL RD. SW, ATLANTA 30311
HAUN,COSMO L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
HAVERTY,JOHN RHODES 29 ACT PD
UNIVERSITY PLAZA, ATLANTA 30303
HAWK,JUDSON LOUIS,JR. 29 ACT PD
3162 PIEDMONT RD., NE, ATLANTA 30305
HAWKINS,KATRINE RAWLS 55 ACT FP
P. O. BOX 518, SYLVANIA 30467
HAY,S. H. 60 ACT I
TOCCOA 30577
HAYES,THOMAS E. 70 ACT SU
102 MEMORIAL MEDICAL BLDG CHATTANOOGA 37404
HAYES,WILLIAM H. 47 ACT PATH
1905 7TH AVE., COLUMBUS 31901
HAYMORE,JAMES M. 07 ACT FP
BOX 578, BLUE RIDGE 30513

HAZELHURST,W. DERREL 06 ACT I
765 SPRING ST., MACON 31201
HAZOURI,LOUIS A. 47 ACT NS
P. O. BOX 5306, COLUMBUS 31906
HEAD,D. L.,JR. 69 ACT FP
E. THOMPSON ST., THOMASTON 30286
HEADLEY,WM. MCKENDREE 02 ACT SU
811 N. COBB ST., MILLEDGEVILLE 31061
HEARD,JOHN P. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030
HEARIN,DAVID L. 29 ACT D
3158 MAPLE DR. N. E., ATLANTA 30305
HEATH,GEORGE S. 72 ACT FP
P. O. BOX 1131, WAYCROSS 31501
HEATH,HEZEKIAH K.,JR. 72 ACT
P. O. BOX 1131, WAYCROSS 31501
HEATH,TIM RAY 29 ACT SU
3280 HOWELL MILL RD,327, ATLANTA 30327
HEATON,SAMUEL A.,JR. 34 A FP
LAURENS CO. HEALTH DEPT., DUBLIN 31021
HECHT,HOWARD L. 29 ACT OR
5675 P'TREE-DUNWOODY RD,NE, ATLANTA 30342
HEFFERNAN,J. ANTHONY,JR 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405
HEILMAN,RICHARD B. 29 ACT IND
BOX 13083, ATLANTA 30310
HEIN,DAVID E. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312
HELLENGA,IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577
HELTON,B. L. 74 DE5 FP
524 WASHINGTON AVE., SANDERSVILLE 31082
HELTON,WILLIAM S. 74 ACT FP
522 WASHINGTON AVE., SANDERSVILLE 31082
HENDEE,ARMAND ELKIN 29 ACT OBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HENDERSON, KENNETH C. 06 ACT PD
777 HEMLOCK ST., MACON 31208
HENDERSON,CHARLES T. 17 ACT SU
521 CAMPBELL HILL ST., MARIETTA 30060
HENDERSON,WARREN S. P. 02 ACT SU
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
HENDI,SAMIR A. 68 ACT SU
HOSPITAL STREET, FRANKLIN 30217
HENDLEY,JOHN ELL 08 ACT FP
101 E. COLLEGE AVE., MILLEN 30442
HENDRICK,A. G. 36 ACT FP
1100 SWIFT ST., PERRY 31069
HENDRICKS,CHAS M.,JR. 42 S I
V A CENTER, DUBLIN 31021
HENDRICKS,WILLIS M. 68 ACT OBG
LAGRANGE 30240
HENDRIX,ARTHUR M. 14 ACT FP
MEDICAL LANE, CANTON 30114
HENDRIX,VERNON J. 29 ACT OBG
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
HENDRY,CHARLES H. 16 ACT P
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
HENDRY,KATHERINE MCM. 72 ACT FP
P.O. BOX 408, BLACKSHEAR 31516
HENDRY,WM. A. 72 DE1 FP
BLACKSHEAR 31516
HENRY,GEORGE M. 06 ACT P
1055 WALNUT ST., MACON 31201
HENRY,GEORGE T. 59 ACT FP
BARNESVILLE 30204
HENRY,J. LAMONT 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HENSLEY,E. A. 54 DE1
GIBSON 30810
HENSLEY,E. R. 09 ACT
MEDICAL CENTER OF CENTRAL GA., MACON 31201
HENSON,PAUL E.,JR. 76 ACT U
MEDICAL ARTS. BLDG., DALTON 30720
HERNANDEZ,FERNANDO G. 36 ACT I
511-A N. HOUSTON RD., WARNER ROBINS 31093
HERNANDEZ,JULIO 01 ACT FP
301 W. PARKER, BAXLEY 31513
HERNANDEZ,R. J. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
HERNDON,EUCLID G.,JR. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HERNDON,JOHN W. 18 ACT FP
OCILLA RD., DOUGLAS 31533
HERRIN,E. V. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
HERRING,JOHN S.,JR. 06 ACT OBG
675 NEW ST., MACON 31201
HERRON,JAMES G. 61 ACT I
1102 E. LAMAR AVE., AMERICUS 31709
HERSH,THEODORE 29 ACT GE
1365 CLIFTON RD. NE, ATLANTA 30322
HERTELL,JOSEPH A. 29 ACT I
3001 N. FULTON DR. NE, ATLANTA 30305
HESTER,THOMAS R.,JR. 19 ACT SU
S. MAIN ST., MOULTRIE 31768
HETHERINGTON,THOMAS A. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
HEWELL,GUY C. 29 DE5 OBG
1123 BERKSHIRE RD. NE, ATLANTA 30306
HICKS,L. G.,JR. 33 ACT ANES
CLARKESVILLE 30523
HIERN,BARRIE C. 27 ACT ANES
122 SADDLE MOUNTAIN RD., ROME 30161
HIGGINS,ALEXIS C. 45 ACT PM
1224 OLD MILL RD., AUBURN,ALA. 36830
HIGHTOWER,JOHN A. 30 ACT I
4101 RIVERSIDE DR., BRUNSWICK 31520
HILL, ROBERT S. 54 ACT SU
1503 WINTER ST., AUGUSTA 30904
HILL,JOHN B. 15 ACT OBG
740 PRINCE AVENUE, ATHENS 30601
HILL,JULIUS N.,III 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
HILL,WM. H. 29 ACT SU
3280 HOWELL MILL RD,NW,201, ATLANTA 30327
HILLIS,CHARLES L. 70 ACT FP
P. O. BOX 846, LAFAYETTE 30728
HILSMAN,A. H.,III 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
HILSMAN,J. H. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HILSMAN,P. L. 23 ACT OBG
1599 MEMORIAL DR. SE, ATLANTA 30317
HINER,JERRY L. 56 ACT FP
BOX 898, BAKER,MONTANA 59313
HINES,ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161
HINKLE,JAMES E. 29 ACT ANES
1000 JOHNSON FERRY RD., ATLANTA 30342
HINTON,GOLDEN S. 15 ACT OPH
957 BAXTER ST., ATHENS 30601
HIRSCH,JACK 47 ACT I
909 CENTER ST., COLUMBUS 31901
HIRT,ALFREDO 29 ACT U
490 PEACHTREE ST. NE, ATLANTA 30308
HITT,WILLIAM A. 75 ACT FP
STE.216,520 OCEAN BLVD., ST. SIMON'S 31522
HIXSON,GORDON L. 70 ACT R
TRI COUNTY HOSPITAL, FT. OGLETHORPE 30742
HLEAP,DAVID 13 ACT FP
DOCTORS BLDG., CUMMING 30130
HOBBY,A. WORTH 29 DE5 PUL
490 PEACHTREE ST. NE, ATLANTA 30308
HOBBY,CHARLES F. 56 ACT R
104 DOCTORS BLDG., VALDOSTA 31603
HOBBY,LOVIC W. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
HOBSON,JOHN L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520
HOCKENHULL,JOHN A. 29 ACT FP
P. O. BOX 188, NICHOLLS 31544
HODGES,C. HUBERT,JR. 65 ACT U
808 GORDON AVE., THOMASVILLE 31792
HODGES,CHAS. A.,JR. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31601
HODGES,HUGH O. 03 ACT FP
703 E. BROAD ST., WINDER 30680
HODGES,JOHN M. 17 ACT SU
805 CAMPBELL ST., MARIETTA 30062

HODGES,MALCOLM R. 06 ACT FP
1221 NEWBURG AVE., MACON 31206
HODGES,THOMAS L. 33 ACT I
WILDWOOD CIRCLE, CLARKESVILLE 30523
HOFFMAN,BYRON J. 29 ACT I
768 JUNIPER ST. N. E., ATLANTA 30308
HOFFMAN,FRANK 11 ACT ALR
24 MEDICAL ARTS CENTER, SAVANNAH 31405
HOFFMAN,JAMES C.,JR. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
HOFFMAN,JOSEPH J.,JR 29 ACT SU
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
HOGAN,J. T.,JR. 06 ACT FP
781 SPRING ST., MACON 31201
HOGSETTE,GERALD B. 55 ACT SU
P.O. BOX 179, SYLVANIA 30467
HOGUE,WILLIAM L. 54 ACT R
TALMADGE HOSP., AUGUSTA 30904
HOLBROOK,WM. H.,JR 15 ACT R
797 COBB ST., ATHENS 30601
HOLDEN,M. H. 42 ACT FP
VA CENTER, DUBLIN 31021
HOLDEN,WILLIAM H. 06 DE5 ALR
%HS COLBATH, 380 RIVERDALE RD, MACON 31204
HOLDER,F. P.,JR. 50 ACT SU
P. O. BOX 569, EASTMAN 31023
HOLDER,J. S. 68 ACT SU
LAGRANGE 30240
HOLLADAY,WM. EDWARD,JR. 17 ACT
787 CAMPBELL HILL ST., MARIETTA 30062
HOLLAND,BERNARD C. 29 ACT P
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
HOLLEY,JACOB H. 21 ACT FP
DONALSONVILLE 31745
HOLLIS,CHARLES D.,JR. 23 ACT I
P. O. BOX 288, ALBANY 31702
HOLLOMAN,J. J. 11 ACT FP
313 E. HALL STREET, SAVANNAH 31401
HOLLOWAY, JOHN T. 75 ACT FP
1101 CHURCH ST., WAYCROSS 31501
HOLLOWAY,ALFRED M. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286
HOLLOWAY,CHAS. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
HOLLOWAY,EMORY W.,JR. 37 A FP
P. O. BOX 126, COMMERCE 30529
HOLLOWAY,GEORGE A. 29 DE5 OBG
2827 CAREYGATE,NW, ATLANTA 30305
HOLLOWAY,WILMER O. 66 ACT
P.O. BOX 388,210 VICTOR DR., TIFTON 31794
HOLMAN,C. M. 23 ACT OBG
410 FOURTH AVE., ALBANY 31705
HOLMES,DEAN LEE 74 ACT
524 SPARTA RD., SANDERSVILLE 31082
HOLMES,WILLIAM C. 15 DE2 FP
740 PRINCE AVENUE, ATHENS 30601
HOLT,EDWARD 56 ACT FP
807 N. PARRISH AVE., ADEL 31620
HOLTON,JOHN B. 29 ACT R
35 BUTLER ST. SE, ATLANTA 30303
HOMEYER,W. F.,JR. 06 ACT ANES
1654 TWIN PINES DR., MACON 31201
HOOD, E. WALTER 29 ACT I
275 CARPENTER DR.,NE, ATLANTA 30328
HOOD,E. D. 11 ACT FP
241 ABERCORN ST., SAVANNAH 31401
HOOD,HERB L. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702
HOOPER,ROBERT J. 06 ACT OPH
645 FIRST STREET, MACON 31201
HOOSE,ELDON E. 22 ACT FP
3644 CHAMBLEE TUCKER RD., CHAMBLEE 30341
HOOSE,KENNETH A.,JR. 22 ACT I
1276 MCCONNELL DR., DECATUR 30033
HOPKINS,RALPH D. 34 ACT R
HALL CO. HOSP., GAINESVILLE 30501
HOPKINS,WM. A. 29 ACT SU
1938 PTREE RD., NW #303, ATLANTA 30309
HORN,EDGAR B. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901
HORNBERGER,R. B. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
HORSEMAN,ROBERT W. 54 ACT ANES
RT. 1, BOX 249, EVANS 30809
HORTMAN,H. C. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161
HOTALEN,WM. B. 29 ACT IND
3384 PTREE RD. NE, ATLANTA 30326
HOUSE, FREDERICK C. 54 ACT ALR
DOCTORS HOSP MEDICAL PLAZA, AUGUSTA 30904
HOUSE, ROBERT O. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
HOUSE,JOHN C. 03 ACT FP
703 E. BROAD ST., WINDER 30680
HOUSER,FRANK M. 06 ACT FP
781 SPRING ST., MACON 31201
HOUSTON,JOSEPH S. 56 ACT P
100 S. EDGEWOOD DR, DOTHAN AL 36301
HOUSTON,JOSEPH S. 56 ACT P
305 EMORY ST., VALDOSTA 31603
HOWARD,CHARLES K. 29 A SU
5084 N. PEACHTREE, DUNWOODY 30338
HOWARD,EDWARD K. 47 ACT SU
MEDICAL CENTER, COLUMBUS 31902
HOWARD,JAMES W. 29 R FP
1761 FONTAINE DR., JONESBORO 30236
HOWARD,JOHN C. 11 ACT OALR
317 E. HALL STREET, SAVANNAH 31401
HOWARD,LEE,JR. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403
HOWARD,PEGGY J. 72 ACT OBG
408 ZACHRY ST., WAYCROSS 31501
HOWARD,ROBERT M. 11 DE1 PATH
622 E. 44TH ST., SAVANNAH 31406
HOWARD,T.J. 54 ACT FP
2316 WRIGHTSBORO RD., AUGUSTA 30904
HOWARD,WILLIAM R. 02 ACT D
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
HOWELL,BARBARA P. 29 ACT FP
620 PEACHTREE ST. NE, ATLANTA 30308
HOWELL,EDGAR V.,JR. 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
HOWELL,TOM S.,JR. 29 ACT SU
620 PEACHTREE ST. NE, ATLANTA 30308
HOWELL,WM. HARVEY 04 ACT
41 NELSON ST., CARTERSVILLE 30120
HOWINGTON,JERRY W. 54 ACT R
UNIVERSITY HOSPITAL, AUGUSTA 30902
HOWLAND,W. SLOCUM,JR. 29 ACT OR
3250 HOWELL MILL RD., NW , ATLANTA 30327
HOWSE,RALPH M. 27 ACT U
1825 MARTHA BERRY HWY., ROME 30161
HUBBARD,DONALD E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
HUBBARD,GEORGE B.,JR. 47 ACT OPH
2019 7TH AVENUE, COLUMBUS 31904
HUBBARD,JAMES A. 23 ACT OBG
401 S. MADISON, ALBANY 31701
HUBBELL,ROBT. W. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033
HUBERT,M. A. 15 DE5 U
466 HIGHLAND AVE., ATHENS 30601
HUDGINS,HERBERT A. 29 S PH
50 SEVENTH ST. NE, ATLANTA 30323
HUDGINS,WILLIAM BAIRD 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
HUDSON,CARLTON B. 04 ACT R
15 WOODVIEW DR., CARTERSVILLE 30120
HUDSON,JACK 54 ACT FP
SOUTHGATE PLAZA, AUGUSTA 30906
HUDSON,JAMES B. 54 ACT I
TALMADGE MEM. HOSP., AUGUSTA 30902
HUDSON,RONALD M. 47 ACT
MEDICAL CENTER, COLUMBUS 31902
HUDSON,W. LLOYD 47 ACT PD
PHYSICIANS BLDG., COLUMBUS 31901
HUFF,PRENTIS BAKER 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
HUFF,THOMAS A. 54 ACT EN
MEDICAL COLLEGE OF GA., AUGUSTA 30904

HUG,CARL C.,JR. 29 ACT ANES
69 BUTLER ST. SE, ATLANTA 30303
HUGER,WILLIAM,JR. 29 ACT PL
35 COLLIER RD. NW, ATLANTA 30309
HUGHES,ANDREW J. 06 ACT FP
3741 HOUSTON AVE., MACON 31201
HUGHES,D. JAMES 29 ACT I
755 COLUMBIA DR., DECATUR 30030
HUGHES,JOE L. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
HUGHES,JOHN L. 54 ACT P
STEVENS CREEK RD.-F, MARTINEZ 30907
HUGHES,RONALD M. 66 ACT OPH
P.O. BOX 986, TIFTON 31794
HUGHSTON,JACK C. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901
HUGULEY,CHAS. M.,JR. 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
HUIE,LYNN M. 71 ACT FP
MONROE 30655
HUIE,RALPH A.,JR. 29 ACT I
774 CLEMONT RD. NE, ATLANTA 30306
HULL,DAVID S. 54 ACT OPH
MEDICAL COLLEGE OF GA., AUGUSTA 30902
HULSEY,W. G. 36 ACT
1115 MORNINGSIDE DR., PERRY 31069
HUMPHREYS,JOHN L. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
HUMPHRIES,ARTHUR L.,JR. 54 ACT SU
TALMADGE MEM. HOSP., AUGUSTA 30902
HUNNICUT,J. A. 15 DE5 FP
1070 S. MILLEDGE, ATHENS 30601
HUNT,JAMES 13 ACT FP
P. O. BOX 398, DULUTH 30136
HUNT,JESSE L. 30 ACT
BOX 1518, BRUNSWICK 31520
HUNT,THOMAS JEFFERSON 59 ACT SU
610 S. 8TH ST., GRIFFIN 30223
HUNTER,CONWAY W.,JR. 29 ACT OBG
3250 HOWELL MILL RD. NW, ATLANTA 30327
HURD,RICHARD A.,JR. 29 ACT OR
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
HURST,J. WILLIS 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
HURST,JAMES B. 06 ACT PATH
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061
HURT,MARION W. 74 ACT FP
109 W. CHURCH ST., SANDERSVILLE 31082
HUTCHESON,MORRIS W. 11 ACT PD
5102 PAULSEN ST., SAVANNAH 31406
HUTCHINSON,J. R. B. 29 ACT OTO
144 PONCE DE LEON AVE. NE, ATLANTA 30308
HUTCHINSON,W. L. 68 ACT OBG
311 S. LEWIS STREET, LAGRANGE 30240
HUTCHISON,NORTON H. 70 R FP
P.O. BOX 366, BELL BUCKLE,TN 37020
HUTTENBACH,DIRK E. 17 ACT P
627 CHEROKEE ST. NE, MARIETTA 30060
HYDEN,WM. U. 27 ACT
TRION 30753
HYDRICK,JOHN T. 29 ACT OBG
960 JOHNSON FERRY RD., #245, ATLANTA 30342
HYDRICK,PETER 29 ACT OBG
1100 CLEVELAND AVE., 201, EAST POINT 30344
HYERS,JOHN J. 29 ACT ANES
5 CHAUMONT SQUARE NW, ATLANTA 30327
HYMAN,BARRY N. 29 DE2 OPH
10119 BRIAR FOREST, HOUSTON, TX 77042

I

IHNEN,MENARD 54 ACT PATH
LAB., UNIV. HOSPITAL, AUGUSTA 30902
INGLIS,E. P.,JR. 17 ACT
1308 CHURCH STREET, MARIETTA 30062
INGRAHAM, RODDY P. 76 ACT PD
MEDICAL ARTS BLDG.,E, DALTON 30720
INGRAM, CHESTER W. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
INMAN,J. S.,JR. 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31705
INMAN,WM. O.,JR. 30 ACT FP
2700 PARKWOOD DR., BRUNSWICK 31520
INSIGNARES,MANUEL S. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
IRELAND,CHARLES R. 06 ACT I
380 HOSPITAL DRIVE, MACON 31201
ISELE,ANTHONY F. 23 ACT PATH
P. O. BOX 1908, ALBANY 31702
ISENBERG,SIDNEY 29 ACT P
44 25TH ST. NE, ATLANTA 30309
ISRAEL,PHILIP Z. 17 ACT SU
3001 S. COBB DR. SE, SMYRNA 30080
IVEY,C. RAY,JR. 36 ACT FP
1554 WATSON BLVD., WARNER ROBINS 31093
IVEY,JOHN C. 29 DE5 SU
BOX 309, MEANSVILLE 30256

J

JABLOW,MITCHELL A. 17 ACT FP
2550 WINDY HILL RD, MARIETTA 30062
JACKSON,BILLY JOE 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501
JACKSON,GORDON W. 06 ACT OBG
380 HOSP. DR., MACON 31201
JACKSON,HENRY C. 45 ACT FP
MANCHESTER 31816
JACKSON,J. H. 59 DE5 FP
10 MARKET ST., BARNESVILLE 30204
JACKSON,JAMES W. 11 ACT SU
1 MED. ARTS CENTER, SAVANNAH 31405
JACKSON,JOSEPH M. 24 ACT FP
MCCOY-JACKSON HOSPITAL, FOLKSTON 31539
JACKSON,ROBERT W. 65 AF ORS
P. O. BOX 978, THOMASVILLE 31792
JACKSON,THOMAS W. 27 ACT OBG
326 MC CALL BLVD., ROME 30161
JACKSON,ZACH W. 29 DE5 OPH
1956 N. RIDGEWAY RD. NE, ATLANTA 30345
JACOBS,IVEY 72 ACT ALR
P. O. BOX 882, WAYCROSS 31501
JACOBS,JOHN L. 29 DE5 AL
490 PEACHTREE ST. NE, ATLANTA 30308
JACOBS,JULIAN 29 S I
VA HOSP., P.O. BOX 29457, ATLANTA 30329
JACOBS,L. DAVIS 72 ACT FP
403 LISTER ST., WAYCROSS 31501
JACOBS,LOUIS JERRY 02 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062
JACOBSON,ALAN I. 17 ACT PATH
P. O. BOX 665, MABLETON 30059
JAEGER-LEE, DOROTHY S. 29 ACT P
165 1365 CLIFTON RD.,NE, ATLANTA 30322
JAFFE,STEVEN L. 29 ACT P
6500 VERNON WOODS DR. NE, ATLANTA 30328
JAMES,C. W.,JR. 06 ACT FP
3741 HOUSTON AVE., MACON 31206
JAMES,FLOYD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501
JAMES,LILLAS L. 06 ACT FP
729 PINE ST., MACON 31201
JAMES,W. SCOTT 29 ACT PD
275 CARPENTER DR., ATLANTA 30328
JANECZKO, GREGORY F. 47 S ANES
MARTIN ARMY HOSPITAL, FT. BENNING 31905
JANSEN, GEORGE A.,JR 76 ACT ANES
1700 SOUTHMONT DR., DALTON 30720
JANTER,THOMAS B. 22 ACT PD
4536 CHAMBLEE-DNWDY RD #201, CHAMBLEE 30341
JARDINA,PHILIP M. 22 ACT I
711 CHURCH ST., DECATUR 30030
JARDINE,DAN A. 18 ACT SU
DOUGLAS 31533
JARMAN,JULIAN A. 29 S SU
P. O. BOX 29457, ATLANTA 30329
JARRARD,GEORGE T. 20 ACT I
P. O. BOX 609, NEWNAN 30263

JARRAT,W. D. 06 ACT OPH
626 FIRST ST., MACON 31201
JARRELL,FLOYD C.,JR. 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901
JARRELL,HAROLD G. 47 ACT OBG
629 20TH STREET, COLUMBUS 31904
JARRELL,ROBERT J. 15 ACT R
ATHENS GENERAL HOSP., ATHENS 30601
JARRELL,SHELBY E. 23 ACT EM
RT. 1,BOX 149P, BACONTON 31716
JARRETT, EUGENE C.,III 65 ACT PD
SOUTHWESTERN STATE HOSP, THOMASVILLE 31792
JARRETT,HENRY K.,JR. 66 ACT U
113 EAST SECOND STREET, TIFTON 31794
JARRETT,WM. H. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
JARVIS,JACK R. 29 S P
35 PUTNAM CIRCLE,NE, ATLANTA 30342
JEANS,PARK C.,JR. 54 ACT OPH
1021 15TH ST., AUGUSTA 30902
JELENKO,CARL,III 54 ACT SU
TALMADGE MEM. HOSP., AUGUSTA 30902
JELKS,LOUIS R. 57 ACT SU
JELKS CLINIC, BOX 128, REIDSVILLE 30453
JENKINS,BEN H. 20 ACT OALR
P. O. BOX 1120, NEWNAN 30263
JENKINS,CHESTER W. 47 S P
1930 PEPPERELL PKWY., OPELIKA,ALA. 36801
JENKINS,JAMES H. 27 ACT OBG
1142 E. CLUB LANE, ATLANTA 30319
JENKINS,O. W. 27 R FP
LINDALE 30147
JENKINS,W. F. 47 DE5 R
1636 DIXON DR., COLUMBUS 31906
JENNINGS,C. M. 17 ACT I
641 CHURCH STREET, MARIETTA 30060
JENNINGS,E. R. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520
JENNINGS,HENRY S.,JR. 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
JENNINGS,JANE B. 11 ACT PATH
P. O. BOX 6688, SAVANNAH 31404
JENNINGS,ROBERT E. 58 ACT
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
JENNINGS,W. D.,JR. 54 ACT SU
V. A. HOSPITAL, AUGUSTA 30904
JERNIGAN,STERLING H. 29 ACT SU
3280 HOWELL MILL RD.,NW,201, ATLANTA 30308
JERNIGAN,WM. C. T. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
JINICH,HORACIO 29 ACT GE
1365 CLIFTON RD.,NE, ATLANTA 30322
JOEL,CHARLES,JR. 29 S N
1670 CLAIRMONT RD. NE, DECATUR 30033
JOHN,FARES 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30904
JOHNS,CHARLES W. 06 ACT FP
3741 HOUSTON AVE., MACON 31206
JOHNSON,A. M. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603
JOHNSON,A. S.,JR. 12 ACT FP
LAUREL DR., ELBERTON 30635
JOHNSON,A. S.,SR. 12 DE5 OALR
46 LAUREL DR., ELBERTON 30635
JOHNSON,ALLYN C.,JR. 34 ACT I
429 E. SPRING STREET, GAINESVILLE 30501
JOHNSON,C. D. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
JOHNSON,C. M. 30 ACT FP
520 OCEAN BLVD., ST. SIMONS IS. 31522
JOHNSON,C. V. 29 ACT P
2151 PEACHFORD RD., ATLANTA 30341
JOHNSON,CHARLES E. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30342
JOHNSON,CHARLES G. 16 ACT FP
409 ARROWHEAD BLVD BLDG B, JONESBORO 30236
JOHNSON,CLARENCE E.,JR. 06 ACT SU
870 HIGH STREET, MACON 31201
JOHNSON,E. G. 70 ACT SU
102 MEMORIAL MEDICAL BLDG CHATTANOOGA 37404
JOHNSON,EDWARD D. 29 ACT SU
3580 ATLANTA AVE., HAPEVILLE 30354
JOHNSON,EDWARD L. 22 ACT OR
2910 N. DRUID HILLS RD., ATLANTA 30329
JOHNSON,G. HUGO,JR. 11 DE5
116 E. OGLETHORPE AVE., SAVANNAH 31401
JOHNSON,HENRY C.,JR. 29 ACT R
35 COLLIER RD. NW, ATLANTA 30309
JOHNSON,JAMES A.,III 29 A R
5221 ESSEX FARMS LANE, STONE MOUNTAIN 30083
JOHNSON,JIMPSEY B. 54 ACT R
MED. COLLEGE OF GEORGIA, AUGUSTA 30902
JOHNSON,JULIUS T. 54 ACT P
1467 HARPER ST. #F, AUGUSTA 30902
JOHNSON,L. MALCOLM 29 ACT FP
401 PEACHTREE ST NE #300, ATLANTA 30308
JOHNSON,LEWIS D. 22 ACT I
4303 LAVISTA RD., TUCKER 30084
JOHNSON,MARGARET W. 20 ACT PATH
P. O. BOX 20262, BIRMINGHAM, ALA 35216
JOHNSON,MARTIN L. 10 ACT
BOWDON 30108
JOHNSON,MARVIN E. 54 ACT PATH
439 SCOTTS WAY, AUGUSTA 30904
JOHNSON,MCCLAREN 29 ACT GE
478 PEACHTREE ST. NE, ATLANTA 30308
JOHNSON,MILTON I.,JR. 06 ACT FP
2605 CHEROKEE AVE., MACON 31204
JOHNSON,NORMAN,JR. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
JOHNSON,OTTO B.,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
JOHNSON,R. JULIAN 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
JOHNSON,RICHARD HARDIN 29 ACT I
2045 PEACHTREE RD. NE, ATLANTA 30309
JOHNSON,ROY J.,JR. 05 ACT FP
MEDICAL ARTS BLDG., FITZGERALD 31750
JOHNSON,THOMAS D. 23 ACT I
P. O. BOX 288, ALBANY 31702
JOHNSON,WALTER E.,JR. 54 ACT ANES
501 MILLEDGE RD APT 7-C, AUGUSTA 30904
JOHNSTON,FRANK M. 11 ACT PN
5105 PAULSEN ST.,STE 140, SAVANNAH 31405
JOHNSTON,G. A. 06 ACT
755 MONROE STREET, MACON 31201
JOHNSTON,HARRY B.,JR 76 ACT FP
500 N. THIRD AVE., CHATSWORTH 30705
JOHNSTON,JOSEPH F. 34 ACT ANES
689 ROBINHOOD TR., GAINESVILLE 30501
JOINER,HARTWELL 34 DE5 I
319 N. BRADFORD ST., GAINESVILLE 30501
JOINER,JAMES C.,III 22 ACT OPH
755 COLUMBIA DR., DECATUR 30030
JOINER,R. M. 19 ACT PD
MOULTRIE 31768
JOINES,IVERSON W.,II 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
JOLLEY,FLEMING L. 29 ACT NS
EMORY CLINIC BUILDING, ATLANTA 30322
JONES, BARRY N. 29 ACT P
1970 CLIFF VALLEY WAY,NE, ATLANTA 30329
JONES,A. P. 59 ACT FP
BOX 757, GRIFFIN 30223
JONES,ARTHUR B.,JR. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
JONES,CARL C.,JR. 29 ACT AL
3316 PIEDMONT RD., ATLANTA 30305
JONES,CHARLES M. 29 A FP
1264 BILTMORE DR.,NE, ATLANTA 30329
JONES,E. LADD,JR. 29 ACT OR
3250 HOWELL MILL RD. NW, ATLANTA 30327
JONES,ELLIS L. 29 ACT TS
1365 CLIFTON RD.,NE, ATLANTA 30322
JONES,ERNEST J. 22 ACT FP
2644 CANDLER PKWY., DECATUR 30030
JONES,FOREST D. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
JONES,G. FRANK,JR. 54 ACT SU
2266 WRIGHTSBORO ROAD, AUGUSTA 30904

JONES,GEORGE R. 06 ACT OPH
626 FIRST ST., MACON 31201
JONES,GEORGE R. 22 ACT FP
3596 CHAMBLEE TUCKER RD., CHAMBLEE 30341
JONES,GEORGE W.,JR. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
JONES,HENRY B.,JR. 06 ACT
GRAY 31032
JONES,HERMAN D.,PH.D. 29 H
209 LEE DR., AUBURN, ALA. 36830
JONES,HURLEY D.,JR. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520
JONES,J. SHERWOOD 76 ACT I
MEMORIAL DR., DALTON 30720
JONES,JOHN P. 06 ACT PD
885 PINE ST., MACON 31201
JONES,KENNETH D. 54 ACT P
EXEC PK. F, #526, MARTINEZ 30907
JONES,LEWIS E. 29 S I
1670 CLAIRMONT RD., DECATUR 30033
JONES,MERWOOD M. 29 ACT OBG
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
JONES,NORMAN E. 29 ACT R
315 BOULEVARD,NE, ATLANTA 30312
JONES,R. LANIER 29 ACT I
2981 CHURCH ST., EAST POINT 30334
JONES,RICHARD B. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
JONES,ROBERT H. 06 ACT I
675 NEW ST., MACON 31201
JONES,ROBERT T. 70 S
LAFAYETTE 30728
JONES,RUDOLPH W.,JR. 06 ACT I
883 PINE STREET, MACON 31201
JONES,W. R. 47 DE5 PD
3055 SAGE RD., HOUSTON, TEXAS 77000
JORDAN,CARL R. 11 ACT SU
P.O. BOX 3567, STA. B, SAVANNAH 31404
JORDAN,CHARLES G. 14 ACT FP
TATE CLINIC, TATE 30177
JORDAN,STEPHEN M. 08 ACT I
356 NORTHSIDE DR.,E., STATESBORO 30458
JORDAN,TOMMY H. 34 ACT P
500 SPRING ST. NE, GAINESVILLE 30501
JORDAN,W. DANIEL 29 ACT SU
490 PEACHTREE ST., #365-C, ATLANTA 30308
JORDAN,W. P. 47 DE5 U
2875 EDGEWOOD DRIVE, COLUMBUS 31906
JORDAN,WILLIAM K. 06 ACT OBG
675 NEW ST., MACON 31201
JOSEF,AVELINO S. 72 ACT SU
203 S. DIXON ST., ALMA 31510
JOSEPH,ALFRED 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344
JOSEPHS,ALVIN D. 29 S I
1670 CLAIRMONT RD., DECATUR 30033
JOSEY,JOHN S. 30 ACT OPH
3010 HAMPTON AVE., BRUNSWICK 31520
JOSEY,WILLIAM E. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
JOVE,DONNA F. 29 ACT PATH
1216 ARBOR VISTA DR. NE, ATLANTA 30329
JOVE,JULIO 22 ACT OR
3644 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
JOWERS,J. R. 54 ACT FP
210 OAK ST., MARTINEZ 30907
JUDY,JAMES C. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
JUN,CHANNING S. 50 ACT SU
702 SECOND AVE. W., EASTMAN 31023
JURGENSEN,PAUL F. 11 ACT I
P. O. BOX 5086, SAVANNAH 31403
JURKIEWICZ,MAURICE J. 29 ACT PL
1365 CLIFTON RD. NE, ATLANTA 30322

K

KAHLE,DAN BRUCE 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
KAHN,ERIC M. 29 ACT SU
353 PARKWAY,NE, ATLANTA 30312
KAHN,S. DAVID 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
KAISER,RICHARD R. 17 ACT PD
3001 S. COBB DR. SE, SMYRNA 30080
KANAVAGE,CHESTER B. 01 ACT SU
413 N. MAIN ST., BAXLEY 31513
KANTER,W. W. 11 ACT
346 BULL ST., SAVANNAH 31402
KANTO,WILLIAM P.,JR. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902
KANTSIPER,ALAN B. 15 ACT R
1230 BAXTER STREET, ATHENS 30601
KAPLAN,BRUCE A. 54 ACT PL
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
KAPLAN,JOEL A. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322
KAPROTH,DAVID E. 65 ACT FP
503 GORDON AVENUE, THOMASVILLE 31792
KARASU,SUAT 29 ACT ANES
627 CHEROKEE ST., MARIETTA 30060
KARATELA,MOHAMED I. 02 ACT P
165 ANNEX DR., MILLEDGEVILLE 31061
KARP,HERBERT R. 29 ACT N
1365 CLIFTON RD.,NE, ATLANTA 30322
KARSTEN,MIKELL B. 66 ACT SU
P.O. BOX 989, TIFTON 31794
KATZ,MYRON M. 16 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236
KAUFMANN,GARY E. 29 ACT NS
2550 WINDY HILL RD. SE, MARIETTA 30062
KAUFMANN,JAMES A. 29 ACT I
950 W. PEACHTREE ST. N. W., ATLANTA 30309
KAVURI,SURENDRANATH 42 ACT PD
112 ROWE ST., DUBLIN 31021
KAY,FERDINAND V. 06 ACT FP
1221 NEWBERG AVE., MACON 31206
KAY,JAMES B.,JR. 54 ACT U
1021 15TH ST., AUGUSTA 30901
KEEN,O. F. 06 DE5 SU
AMERICAN FEDERAL BLDG., MACON 31201
KEENAN,JOSEPH P. 54 I&R
9 BICKFORD ST., SIMSBURY, CT 06070
KEENE,WILLIS R. 24 ACT I
1001 N. THIRD ST., FOLKSTON 31537
KEENER,ELLIS B. 22 ACT NS
365 WINN WAY, DECATUR 30030
KEETON,WILLIAM F. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
KEISLER,DAVID L. 54 A
MEDICAL COLLEGE OF GA., AUGUSTA 30904
KEITH,THOMAS L. 34 ACT ANES
ANES ASSOC OF GAINESVL, GAINESVILLE 30501
KEITH,W. PERRY 23 ACT EM
2708 CAMBRIDGE RD., ALBANY 31707
KELLEHER,ROBERT M. 29 ACT D
6500 VERNON WOODS DR #D-8, ATLANTA 30328
KELLER,A. PAUL,JR. 15 ACT OALR
1010 PRINCE AVE., ATHENS 30601
KELLER,JAMES W. 29 ACT ON
1365 CLIFTON ROAD, NE, ATLANTA 30322
KELLEY, D.C. 13 DE5 FP
370 KROGAN ST NW, LAWRENCEVILLE 30245
KELLEY,CHARLES N. 34 ACT I
710 BROAD ST., GAINESVILLE 30501
KELLEY,D. C. 13 DE5 FP
435 PERRY ST. SW, LAWRENCEVILLE 30245
KELLEY,J. WELDON 59 ACT SU
602 S. 8TH ST., GRIFFIN 30223
KELLEY,ROBERT E.,JR. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
KELLEY,W. A. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
KELLUM,J. M. 69 ACT SU
THOMASTON 30286
KELLY,ELMO C.,III 06 ACT D
700 SPRING ST., MACON 31701
KELLY,GENE M. 06 ACT ANES
148 TEN KNOLLS DR., MACON 31204

KELLY,GORDON M. 54 ACT SU
1467 HARPER ST., AUGUSTA 30902
KELLY,JAMES D. 29 R SU
3113 LENOX RD., ATLANTA 30324
KELLY,JAMES MARVIN 27 ACT OR
310 W. 10TH ST., ROME 30161
KELLY,JULIAN D.,JR. 11 ACT OR
600 E. 65TH ST., SAVANNAH 31405
KELLY,OLIVER 47 ACT ANES
404 DOCTORS BLDG., COLUMBUS 31901
KELLY,ROBERT P.,JR. 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
KELLY,WILLIAM D. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406
KEMBLE,JOHN W. 02 R N
704 RUNNYMEDE CIR., VA. BCH., VA. 23452
KEMPER,CLIFTON G. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
KENIMER,BARRY K. 34 ACT ANES
HALL COUNTY HOSP., GAINESVILLE 30501
KENNEDY,KAREL R. 29 ACT C
215 PIEDMONT AVE APT 709, ATLANTA 30305
KENNEDY,T. EUGENE 13 ACT FP
P.O. BOX 358, BUFORD 30518
KENT,WILLIAM F. 08 ACT OBG
P. O. BOX 1066, STATESBORO 30458
KENT,WILLIAM R. 55 ACT FP
P. O. BOX 218, SYLVANIA 30467
KERLEY,CLIFFORD M. 22 ACT R
5247 FOREST SPRINGS DR., DUNWOODY 30338
KERR,WM. K. 22 ACT FP
P. O. BOX 80525, CHAMBLEE 30341
KESSLER,FRED OTTO,JR. 11 ACT FP
3802 WATERS AVE., SAVANNAH 31404
KETRON,HUBERT W. 29 S I
304 WORTHINGTON DR., MARIETTA 30060
KEULS,HANS A. 61 ACT OBG
1102 E. LAMAR ST., AMERICUS 31709
KIAS,THOMAS N.,JR 15 ACT I
1010 PRINCE AVENUE, ATHENS 30601
KIBLER,JAMES A. 42 ACT P
420 ACADEMY AVE., DUBLIN 31021
KIBLER,ROBERT F. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
KILEY,JAMES D. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30327
KILLEBREW,JAMES G.,JR 68 ACT OR
303 SMITH ST., LAGRANGE 30240
KILPATRICK,WM. H. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
KILPATRICK,ZACHARY M. 54 ACT GE
1467 HARPER ST., AUGUSTA 30902
KIM,CHYUNG M. 29 ACT PD
1468 S. INDIAN CREEK DR., ST. MT. 30083
KIM,H. HAHK 29 ACT PD
2788 BAYARD ST., EAST POINT 30344
KIM,JONG-IN 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
KIM,SOON OK 42 ACT
VA CENTER, DUBLIN 31021
KIM,SUNG H. 50 ACT PATH
GRIFFIN ST., EASTMAN 31023
KIM,TAE W. 23 ACT EM
2010 W. BROAD, ALBANY 31707
KIMMERLING,RICHARD W. 17 ACT SU
2404 AUSTELL RD., AUSTELL 30001
KINARD,GARLAND E. 70 ACT FP
118 HOWARD ST., ROSSVILLE 30741
KING,DELUTHA H. 29 ACT U
2600 GORDON SW,, ATLANTA 30311
KING,GEORGE C. 60 ACT FP
BOX 1209, CLAYTON 30525
KING,J. DUDLEY 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
KING,J. L. 06 DE5 I
283 BUFORD PL., MACON 31201
KING,J. LON,JR. 06 ACT OBG
380 HOSP. DR., MACON 31201
KING,J. T. 65 ACT OALR
THOMASVILLE 31792

KING,JAMES T. 29 DE1 ALR
1890 W. PACES FERRY RD., ATLANTA 30327
KING,JAMES T.,JR. 29 DE2 SU
1287 CUMBERLAND RD., ATLANTA 30306
KING,JOHN LAMAR 59 ACT U
8TH STREET, GRIFFIN 30223
KING,JOHN T.,JR. 65 ACT
P. O. BOX 1919, THOMASVILLE 31792
KING,OLIVER W. 17 ACT SU
3001 S. COBB DR., SMYRNA 30080
KING,RICHARD 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
KING,RICHARD E. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
KING,RUSKIN 11 DE5 PD
10 W. TAYLOR ST., SAVANNAH 31401
KING,SPENCER B.,III 29 ACT C
EMORY UNIV. CLINIC, ATLANTA 30322
KING,STEPHEN 29 ACT PD
6500 VERNON WOODS DR., ATLANTA 30328
KING,STEPHEN H. 15 S I
PO BOX 8043, ATHENS 30601
KING,WILLIAM D. 66 ACT OBG
1493-A KENNEDY RD., TIFTON 31794
KING,WM. R.,JR. 59 ACT SU
708 S. 8TH STREET, GRIFFIN 30223
KINLAW,WM. K.,JR. 22 ACT NS
365 WINN WAY, DECATUR 30030
KIRCHMAN,HERBERT 30 ACT
403 G. STREET, BRUNSWICK 31520
KIRCHNER,ARTHUR B. 29 ACT R
1365 CLIFTON RD.,NE, ATLANTA 30322
KIRKLAND,JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
KIRKPATRICK,J. F.,JR. 66 ACT SU
714 E. 18TH ST., TIFTON 31794
KIRKPATRICK,JAS L.,JR. 17 A I

KISER,ELLEN FINLEY 29 DE5 P
210 PEACHTREE CIR. NE, ATLANTA 30309
KISER,WM. H.,JR. 29 DE5 P
210 PEACHTREE CIR. NE, ATLANTA 30309
KITAY,DAVID Z. 29 ACT OBG
17 PRESCOTT ST., ATLANTA 30303
KITCHENS,S. B. 70 DE5 FP
LAFAYETTE 30728
KITCHENS,WILLIAM R. 19 ACT SU
717 COLONIAL VILLAGE, MOULTRIE 31768
KITCHENS,WM. C. 15 ACT I
740 PRINCE AVE., ATHENS 30601
KITE,J. H. 29 DE5 OR
490 PEACHTREE ST. N. E., ATLANTA 30308
KLAUS,RICHARD M. 29 ACT OR
2550 WINDY HILL RD., #208, MARIETTA 30062
KLEBER,RONALD J. 17 ACT P
84 LACY ST., MARIETTA 30060
KLEIMAN,SCOTT G. 17 ACT OR
3910 AUSTELL RD., AUSTELL 30001
KLEIN,LUELLA M. 29 ACT OBG
80 BUTLER ST. SE, ATLANTA 30303
KLEMANN,GILBERT 23 ACT OBG
901 N. MADISON ST., ALBANY 31701
KLEMANN,GILBERT 23 ACT OBG
1021 15TH ST, AUGUSTA 30901
KLERIS,GEORGE S. 29 A PH
220 FORREST LK. DR. NW, ATLANTA 30327
KLINGBEIL,ROBERT TAYLOR 17 ACT PM
KENNESTONE HOSP., MARIETTA 30060
KLOPPER,RALPH M. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
KLOPSTOCK,WILLIAM J. 29 ACT P
3316 PIEDMONT RD. NE, ATLANTA 30305
KLOTZ,HUGH A. 29 ACT OPH
3316 PIEDMONT RD. NE, ATLANTA 30305
KLUGH,GEORGE F. 29 DE5 PATH
303 N. HORNER BLVD., SANFORD, N. C. 27730
KNELLER,SHELDON 47 S SU
MARTIN ARMY HOSP., FT. BENNING 31906
KNIGHT,EVELYN A. 22 ACT PD
3750 DIAL DR., CLARKSTON 30021

KNOWLES,VAN CISE 23 ACT SU
410 FOURTH AVE., ALBANY 31705
KNOWLTON,JAMES W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
KNOX,JOHN D.,JR. 17 ACT OR
1416 CHEROKEE ST., MARIETTA 30062
KOCACITAK,SAHIN S. 70 ACT SU
TRI-COUNTY HOSP., FT. OGLETHORPE 30742
KOENIG,RONALD H. 29 ACT N
2788 BAYARD ST., EAST POINT 30344
KONAKCI,YUKSEL 29 A PATH

KOZINN, MARK A. 29 ACT N
2788 BAYARD ST., EAST POINT 30344
KOZINN,MARK A. 29 ACT N
1680 MULKEY RD, AUSTELL 30001
KRAATZ,ROBERT 47 ACT PATH
1800 LAKEWOOD DR., PHENIX CITY, ALA 36867
KRAFKA,JOSEPH F. 68 ACT PATH
CITY CO HOSP., VERNON RD, LAGRANGE 30240
KRAININ,MILTON JOSEPH 29 ACT I
1293 PEACHTREE ST. NE, ATLANTA 30309
KRAL,ROBERT A. 29 ACT OBG
2100 PARKLAKE DR. NE, ATLANTA 30345
KRAMER,JOHN H. 22 ACT OPH
4555 N. SHALLOWFORD RD., ATLANTA 30341
KRAVTIN,A. J. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
KREPPS,ARTHUR C.,II 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223
KRUGMAN,PHILIP I. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
KUGLER,MORRIS A. 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31405
KUMAR, VEENI S. 17 ACT PATH
1000 ATLANTA WEST BLVD, LITHIA SPGS 30057
KUMAR,SUSHIL V. 16 ACT FP
1019 ASTOR AVE., FOREST PARK 30050
KUMIN,GERALD D. 29 ACT I
644 CHEROKEE ST., MARIETTA 30062
KURTZ,DONALD M. 47 ACT PATH
P.O. BOX 4176, COLUMBUS 31904
KURTZ,JOSEPH L. 29 ACT OR
401 PEACHTREE ST. NE, ATLANTA 30308
KURZBACH,ELMER 11 ACT FP
314 E. GASTON ST., SAVANNAH 31401
KUSHNAR,ROBERT L.,JR. 17 ACT R
3903 SOUTH COBB DR #105, SMYRNA 30080
KUSKE,TERRENCE T. 54 ACT I
MED COLLEGE OF GA., AUGUSTA 30904
KUTNER,STEPHEN S. 29 ACT OPH
340 BOULEVARD NE, ATLANTA 30312
KWON,OH BONG 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
KYBURZ,BRUCE A. 17 ACT U
1067 LONGWOOD DR.,SW, MARIETTA 30060

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LA CONTE,LEONARD P. 19 ACT R
BOX 608, MOULTRIE 31768
LA MOTTE,IRENE F. 54 ACT
1500 JOHNS RD., AUGUSTA 30904
LACKEY,DIXON A. 29 ACT PD
440 OLD CREED RD.,NE, ATLANTA 30342
LAHMAN,ROSE A. 29 ACT OBG
950 W. PEACHTREE ST. NW, ATLANTA 30309
LAMB,CHARLES C. 23 ACT FP
910 N. JEFFERSON., ALBANY 31705
LAMB,GAIL L 06 ACT
990ST. ANDREWS RD., MACON 31204
LAMBERT,BUFORD L. 54 ACT EM
1350 WALTON WAY, AUGUSTA 30902
LAMBERT,ROBERT Y. 17 ACT SU
2241 LEWIS ST., KENNESAW 30144
LAMIS,PANO A. 29 ACT SU
315 BOULEVARD,NE, ATLANTA 30312
LAMPROS,C. PETER 60 ACT R
800 DOYLE ST., TOCCOA 30577
LANCASTER,HOMER H. 34 DE5 FP
1798 CLEVELAND RD., GAINESVILLE 30501
LANDHAM,JACKSON W.,JR. 59 ACT I
743 S. 8TH ST., GRIFFIN 30223
LANDY,MICHAEL S. 29 ACT I
2739 FELTON DR., EAST POINT 30344
LANE,DONALD R. 29 ACT I
353 PARKWAY DR. NE, ATLANTA 30312
LANE,GEO M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
LANE,W. K. 23 ACT
810 13TH ST., ALBANY 31701
LANFORD,CHARLES A. 06 ACT FP
7405 IND. HWY., MACON 31206
LANG,LEWIS R. 31 ACT FP
323 S. WALL ST., CALHOUN 30701
LANGE,STEPHEN J. 11 ACT FP
509 LEE BLVD., SAVANNAH 31405
LANGE,STEPHEN J.,JR. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
LANGFORD,JAMES F. 29 ACT FP
1143 ALPHARETTA ST., ROSWELL 30075
LANGSTON,WILLIAM T. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
LANIER,BOB G. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
LANIER,LONNIE R.,JR. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
LAPIDES,LEON 47 ACT ALR
309 DOCTORS BLDG., COLUMBUS 31901
LARAMORE,HERBERT F. 29 A PH
654 KIMBERLY LANE NE, ATLANTA 30306
LARDIN,WILLIAM A. 65 ACT ANES
ARCHBOLD MEMORIAL HOSP, THOMASVILLE 31792
LAROCHE,LAURENT P. 29 ACT OCM
2000 N.E. X-WAY, NORCROSS 30071
LAROSE,JAMES H. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
LASKY,RICHARD S. 70 ACT U
1010 E. THIRD ST., CHATTANOOGA, TENN 37403
LASLIE,MICHAEL N. 54 ACT ANES
MCG, AUGUSTA 30902
LASSITER,HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
LASSITER,NOLAN M. 22 ACT I
1275 MCCONNELL DR, DECATUR 30030
LATHAM,ELIZABETH B. 29 ACT PD
3185 WASHINGTON RD., EAST POINT 30344
LATHAN,SAMUEL R. 29 ACT I
1201 PTREE ST. NE, ATLANTA 30361
LAU,FOOK S. 02 ACT I
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
LAVIETES,PAUL A. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
LAWLER,JACK 47 ACT OBG
629 20TH ST., COLUMBUS 31904
LAWRENCE,GEORGE C. 29 ACT OBG
75 PIEDMONT AVE. NE, ATLANTA 30303
LAWRENCE,JAMES D. 06 ACT SU
380 HOSP. DR., MACON 31201
LAWRENCE,JOHN C. 60 ACT PD
800 E. DOYLE ST., TOCCOA 30577
LAWSON,QUENTIN T. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31601
LAYNE,WILLIAM T. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
LEADER,EDWARD 22 ACT P
1970 CLIFF VALLEY RD. NE, ATLANTA 30329
LEAR,THOMAS F.,JR. 65 ACT SU
P. O. BOX 1912, THOMASVILLE 31792
LEBOS,HARVEY C. 11 ACT I
600 E. 70TH ST., SAVANNAH 31406
LEE, DUO LAM 18 ACT R
P.O. BOX 1077, DOUGLAS 31533
LEE,BOTHWELL G. 54 I&R
BOX 717, MCG, AUGUSTA 30902
LEE,EUNG M. 34 ACT I
743 SPRING ST.,NE, GAINESVILLE 30501
LEE,F. LANSING 54 ACT I
1433 GWINNETT ST., AUGUSTA 30902

LEE,FRED M. 60 ACT U
800 E. DOYLE ST., TOCCOA 30577
LEE,HOWARD B. 22 ACT FP
603 CHURCH ST., DECATUR 30030
LEE,JAMES MOULTRIE 11 ACT SU
200 E. 31ST. ST., SAVANNAH 31401
LEE,JOHN E. 29 ACT N
25 PRESCOTT ST., ATL. 30308
LEE,JOON NAM 16 ACT I
555 BATTLE CREEK RD,B-6, JONESBORO 30236
LEE,JOSEPH D. 54 ACT SU
1021 15TH ST., AUGUSTA 30901
LEE,LAWRENCE,JR. 11 ACT I
2203 ABERCORN STREET, SAVANNAH 31401
LEE,MOO HEE 54 ACT PD
409 ARROWHEAD BLVD., JONESBORO 30236
LEE,WALTER E.,JR. 72 ACT FP
BOX 737, WAYCROSS 31501
LEE,YEE W. 23 ACT PD
412 - FOURTH AVE., ALBANY 31705
LEFF,PETER B. 22 ACT I
2054-F LAWRENCEVILLE HWY, DECATUR 30033
LEFKOFF,HAROLD J. 29 ACT OALR
340 BOULEVARD NE, ATLANTA 30312
LEHMAN,RONALD J. 29 ACT OR
4555 N. SHALLOWFORD RD, CHAMBLEE 30341
LEIGH,JAMES H.,JR. 34 ACT SU
194 GOLD ST., GAINSVILLE 30501
LEIGH,RICHARD W. 27 ACT OBG
16 PROFESSIONAL COURT, ROME 30161
LEIGH,TED F. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
LELAND,TOM W. 29 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
LEMLEY,JOHN W. 44 ACT FP
DOCTORS BLDG., THOMSON 30824
LEMON,ROMAN,JR. 54 ACT OBG
3651 WHEELER RD., AUGUSTA 30904
LENNON,ROBERT W. 16 ACT OPH
33 SW UPPER RVDLE RD., RIVERDALE 30274
LENTON,JOHN D. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
LEONARD,JAMES R. 29 ACT OTO
3280 HOWELL MILL RD NW #333, ATLANTA 30327
LEONARD,ROBERT 54 ACT OALR
1109 TELFAIR ST., AUGUSTA 30901
LEONARD,ROBERT P. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
LEONARD,WILLIAM P. 29 ACT SU
3406 OLD PLANTATION RD. NW, ATL 30327
LEONARDY,JOHN G. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
LEROY,ALBERT G. 44 ACT FP
THOMSON 30824
LESCHER,CHARLES F. 59 S R
14627 S.W. 63RD CT., MIAMI, FLA. 33158
LESESNE,ARTHUR E. 29 ACT I
353 PARKWAY NE, ATLANTA 30312
LESLIE,JAMES T. 22 A PD
50 SEVENTH ST. NE., #404, ATLANTA 30323
LESSER,JOSEPH M. 29 ACT FP
400 COLONY SQ, STE. 1605, ATLANTA 30361
LESSLIE,WILLIAM P. 17 ACT I
86 S. COBB DR., MARIETTA 30060
LESTER,JESS C. 29 ACT OPH
478 PEACHTREE STREET NE, ATLANTA 30308
LESTER,WM. M. 29 ACT OB
5675 P'TREE-DNWDY RD,NE, ATLANTA 30342
LETTON,A. HAMBLIN 29 ACT SU
315 BOULEVARD NE, ATLANTA 30312
LEVENSON,DAVID S. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30030
LEVERETT,EDWARD 68 ACT
432 GORDON CIRCLE, LA GRANGE 30240
LEVIN,HAROLD B. 29 ACT D
1293 PEACHTREE ST. NE, ATLANTA 30309
LEVIN,JACK M. 29 ACT PR
340 BOULEVARD NE, ATLANTA 30312
LEVINE, MICHAEL S. 29 ACT GE
2550 WINDY HILL RD.,311, MARIETTA 30062
LEVINE,MICHAEL K. 29 ACT PD
6500 VERNON WOODS DR. NE, ATLANTA 30328
LEVINE,STANLEY H. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
LEVINE,STEPHEN B. 29 ACT PD
5675 P'TREE-DUNWDY RD. NE, ATLANTA 30342
LEVY,CHARLES E. 29 ACT P
3400 PEACHTREE ST. NE, ATLANTA 30326
LEVY,JACK H. 54 ACT R
1425 GWINNETT ST., AUGUSTA 30902
LEVY,LOUIS I. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
LEVY,LOUIS K. 29 ACT I
2045 PEACHTREE RD.,NW, ATLANTA 30309
LEVY,MORENO Y. 29 DE5 FP
221 ROBINHOOD RD. NE, ATLANTA 30309
LEWIS,EARLE 68 DE1 I
303 SMITH ST., LAGRANGE 30240
LEWIS,EDWARD L.,JR. 15 ACT D
1077 BAXTER ST., ATHENS 30601
LEWIS,ERNEST L. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
LEWIS,JAMES W. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
LEWIS,JOHN R.,JR. 29 ACT PL
3316 PIEDMONT RD. NE, ATLANTA 30305
LEWIS,L. K. 49 ACT
BOX 552, MADISON 30650
LEWIS,WILEY B. 72 ACT FP
1507 ALICE ST., WAYCROSS 31501
LEWIS,WM. EARL 06 ACT SU
280 HOSPITAL DR #430, MACON 31201
LEYVA,JOSE S. 16 ACT OBG
33 UPPER RIVERDALE RD #214, RIVERDALE 30274
LICHTMAN,STANLEY 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
LIEVANO,ALVARO 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344
LIGHTNER,JOEL E. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31902
LIGON,WALTER M. 17 ACT OTO
444 FAIRGROUND ST., MARIETTA 30062
LIN,HUI-CHING Y. 29 A I
634 WILSON RD. NW, ATLANTA 30318
LIN,TA-JUNG 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30902
LINDER,CHARLES W. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902
LINDLEY,JACK B. 54 ACT SU
MEDICAL PLAZA BLDG #309, AUGUSTA 30904
LINDSAY,JAMES B. 06 ACT SU
781 SPRING ST., MACON 31201
LINDSEY,I.L. 29 ACT N
960 JOHNSON FERRY ROAD, NE, ATLANTA 30342
LINDSEY,MARK M. 17 ACT FP
155 TRAIL POINT, ATLANTA 30338
LINZ,WERNER A. 68 ACT U
303 SMITH ST., LAGRANGE 30240
LIPMAN,BERNARD S. 29 ACT I
1285 PEACHTREE ST. NE, ATLANTA 30309
LIPPITT,ALAN B. 29 S OTO
U.S. ARMY HOSPITAL, FT. MCPHERSON 30330
LIPPITT,WILLIAM H. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401
LIPSCOMB,GEORGE E. 47 ACT R
P. O. BOX 2787, COLUMBUS 31902
LIPSCOMB,J. WATTS 29 ACT I
6185 JONESBORO RD., MORROW 30260
LIPSCOMB,THOMAS L. 29 ACT
3580 ATLANTA AVE., HAPEVILLE 30354
LIPSITCH, IAN I. 29 ACT P
1365 CLIFTON RD.,NE, ATLANTA 30322
LIPSIUS,L. H. 27 ACT P
1825 MARTHA BERRY BLVD., ROME 30161
LITTLE,ALEX G.,JR. 56 R SU
RT. 1, BOX 4, VALDOSTA 31601
LITTLE,CHARLES H. 34 ACT OR
700 S. ENOTA DR. NE, GAINESVILLE 30501
LITTLE,FRANK A. 65 ACT ANES
109 TUXEDO DR., THOMASVILLE 31792

LITTLE,G. H. 27 DE1 FP
TRION 30753
LITTLE,ROBERT C. 54 ACT C
MED COLLEGE OF GA., AUGUSTA 30904
LITTON,JAMES H. 22 ACT FP
4173 FIRST AVE., TUCKER 30084
LIU,PAUL I. 54 ACT PATH
MED. UNIVERSITY OF SC, CHARLESTON,SC 29401
LLORENTE,TEODULO M. 27 ACT FP
13 JOHNS MADDOX DR., ROME 30161
LOBEL,A. BEATA 22 ACT PD
11 LA VISTA PER OFC PK, TUCKER 30084
LOCKHART,ASA C. 29 A ANES
GRADY MEMORIAL HOSPITAL, ATLANTA 30303
LOFTMAN,BERT A. 29 ACT N
1680 MULKEY RD STE H, AUSTELL 30001
LOGAN,JAMES R. 11 ACT OTO
2203 ABERCORN ST., SAVANNAH 31401
LOGAN,WILLIAM DEWEY,JR. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
LOGUE,H. EDWARD 54 DE2 FP
801 PRINCETON AVE., BIRMINGHAM,ALA. 35901
LOGUE,R. BRUCE 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
LONG,HAROLD G. 34 ACT
P. O. BOX 186, DAHLONEGA 30533
LONG,HAROLD W. 50 ACT FP
P. O. BOX 400, EASTMAN 31023
LONG,ROBERT F. 11 ACT R
P.O. BOX 6688, STA. C, SAVANNAH 31405
LONG,STEWART M. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
LONG,W. NEWTON 22 ACT OBG
80 BUTLER ST. SE, ATLANTA 30303
LONG,W. V. 11 DE5 SU
540 E. 49TH STREET, SAVANNAH 31405
LONG,WILLIAM B. 29 ACT OPH
4303 LAVISTA RD., TUCKER 30084
LONGAKER,PAUL E. 06 ACT FP
4915-G RIVOLI DR., MACON 31204
LONGINO,GRADY E. 42 ACT I
VA CENTER, DUBLIN 31021
LOOPER,BEN KEITH 14 ACT OBG
321 HOSPITAL RD., CANTON 30114
LOPEZ,ERNESTO G. 72 ACT PATH
WAYCROSS MEM. HOSP., WAYCROSS 31501
LOPEZ,JOSE 29 ACT ANES
409 ARROWHEAD BLVD BLDG A, JONESBORO 30236
LOPEZ,ORLANDO O. 29 ACT U
2748 FELTON DR., EAST POINT 30344
LORD,CLYDE O. 29 ACT ANES
501 FAIRBURN RD. SW, ATLANTA 30331
LORENZ,MAX P. 17 ACT U
652 CHURCH ST. NE, MARIETTA 30060
LOTT,OSCAR H. 11 DE1 FP
RFD RT. 2, DOUGLAS 31533
LOTT,THOMAS M. 54 ACT R
1467 HARPER ST., AUGUSTA 30902
LOUGHLIN,EDWARD C. 29 ACT OR
3316 PIEDMONT RD. NE, ATLANTA 30305
LOVE,WILLIAM G.,JR. 47 ACT SU
P. O. BOX 6547, COLUMBUS 31907
LOVELL,WOOD W. 29 ACT OR
321 W. HILL ST., DECATUR 30030
LOVETT,KATHRYN S. 08 ACT P
P. O. BOX 486, STATESBORO 30458
LOVVORN,JOHN R. 27 ACT P
HARBIN CLINIC, ROME 30161
LOWANCE,DAVID C. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
LOWANCE,MASON I. 29 ACT AL
3312 PIEDMONT RD. NE, ATLANTA 30305
LOWENBERG,ROBERT I. 29 ACT SU
4444 AUSTELL RD., AUSTELL 30001
LOWERY,WILLIAM D.,JR. 23 ACT NS
419 FOURTH AVE., ALBANY 31705
LOWRY,THOMAS 22 ACT
2701 N. DECATUR RD,, DECATUR 30033
LUCAS,GEORGE W. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
LUCAS,PAUL WARREN 66 ACT OALR
TIFTON 31794
LUCAS,WALLACE 36 ACT FP
613 E. DYKES ST., COCHRAN 31014
LUCAS,WILLIAM H. 27 ACT I
5 PROFESSIONAL CT., ROME 30163
LUCAS,WILLIAM T. 54 ACT U
1276 MERRY ST., AUGUSTA 30904
LUCKETT,JAMES M. 22 ACT R
2701 N. DECATUR RD., DECATUR 30030
LUKE,B. D. 16 ACT FP
6103 N. MAIN ST., MORROW 30260
LUKE,DANIEL R. 34 ACT FP
1144 VINE ST. NE, GAINESVILLE 30501
LUMPKIN,MURRAY B. 76 ACT SU
P. O. BOX 987, DALTON 30720
LUMSDEN,THOMAS N. 33 ACT FP
P. O. BOX 45, CLARKESVILLE 30523
LUPO,CARL W. 30 DE5 ALR
P. O. BOX 1057, ST. SIMONS ISL. 31522
LUXENBERG,MALCOLM N. 54 ACT OR
1120 15TH ST., AUGUSTA 30902
LYLE, JAMES E. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
LYNCH,LAWRENCE J.,JR. 11 ACT SU
5002 PAULSEN ST.,BLDG. F, SAVANNAH 31405
LYNN,KAY F. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30032
LYNOTT,MARJORIE A. 17 ACT FP
277 FAIRGROUND ST., MARIETTA 30062
LYON,DAVID B. 29 ACT P
2151 PEACHFORD RD., ATLANTA 30341
LYON,HARRY C. 29 ACT FP
537 MORELAND AVENUE SE, ATLANTA 30316
LYON,JAMES B. 29 ACT OBG
710 PEACHTREE ST.,NE, ATLANTA 30308

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MABON,ROBERT 29 ACT NS
35 COLLIER RD. NW, ATLANTA 30309
MACDONELL,FRANK S. 29 ACT D
2756-A FELTON DR., EAST POINT 30344
MACHADO,M. D. 29 ACT ANES
1676 MULKEY RD., AUSTELL 30001
MACIAS,F. M. 59 ACT ANES
24 MAIN ST., HAMPTON 30228
MACKEY,DAN M. 22 ACT D
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30319
MACLEOD, DAVID S. 27 ACT C
HARBIN CLINIC, ROME 30161
MACNABB,GEORGE M. 20 ACT I
P.O. BOX 609, NEWNAN 30263
MACRIS,ALLEN G. 29 ACT TS
490 PEACHTREE ST. NE, ATLANTA 30308
MACWILLIAMS,PETER 29 ACT D
1000 ATL. WEST BLVD., LITHIA SPRINGS 30057
MADDOX,S. F. 06 ACT OPH
800 FIRST ST., MACON 31201
MADDRY,EDGAR L. 42 S ACM
VA CENTER, DUBLIN 31021
MADRELL,ROBERT S. 68 ACT OBG
311 S. LEWIS ST., LA GRANGE 30240
MAGEE,KENNETH G. 22 ACT PD
4536 CHAMBLEE DUNWDY RD., ATLANTA 30341
MAGNAN,C. G.,JR. 06 ACT PL
380 HOSP. DR., MACON 31201
MAGRUDER,RICHARD L.,JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
MAHAN,D. R.,JR. 76 ACT FP
1219 MEMORIAL DR., DALTON 30720
MAHAN,THOMAS P. 29 ACT ANES
3518 PACES PLACE NW, ATLANTA 30305
MAHAYNI,AHMAD S. 05 ACT SU
P.O. BOX 988, FITZGERALD 31750
MAHON,THOMAS M. 22 ACT PD
4112 E. PONCE DE LEON AVE., CLARKSTON 30021
MAHONEY,PAUL D. 54 ACT ANES
3208 MONTPELIER DR., AUGUSTA 30904

MAINOR,ROBERT 17 ACT FP
2874 KING ST. SE, SMYRNA 30080
MAJANOVIC,MAHMUD 02 ACT PUL
149 RIVERSIDE DR., MILLEDGEVILLE 31061
MAJOR,CECIL P. 68 ACT
303 SMITH STREET, LAGRANGE 30240
MAJOROS,MARTON 29 ACT ALR
2719 FELTON DR., EAST POINT 30344
MALCOM, GEORGE E.,JR. 17 ACT EM
3646 OXFORD TR., MARIETTA 30062
MALLORY,JAMES D.,JR. 29 ACT P
3355 LENOX RD. NE, ATLANTA 30326
MALONE,ELLIS L. 17 ACT I
3910 AUSTELL RD., AUSTELL 30001
MALONE,RANDOLPH A. 65 ACT PD
413 GORDON AVENUE, THOMASVILLE 31792
MALONE,THOMAS P. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
MALONEY,GEORGE R. 54 ACT U
1467 HARPER ST., AUGUSTA 30902
MALOY,WILLIAM C. 29 ACT I
272 BOULEVARD NE, ATLANTA 30312
MANCHESTER,THOS. P.,JR. 29 ACT OPH
35 COLLIER RD. NW, ATLANTA 30309
MANER,FREDERICK DEBELE 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
MANGANIELLO,LOUIS O. J. 54 ACT NS
2247 WRIGHTSBORO RD., AUGUSTA 30902
MANGET,FRED P. 20 DE5
3372 OSBORNE PL., MACON 31204
MANGET,J. D.,JR. 29 DE1 FP
26 THIRD ST. NW, ATLANTA 30308
MANIS,ROBERT 29 ACT P
3316 PIEDMONT RD.,NE, ATLANTA 30305
MANN,DAVID S. 06 ACT
645 FIRST STREET, MACON 31201
MANN,FRANK R.,JR. 64 ACT
MCRAE 31055
MANN,GUY W. 56 ACT FP
116 HOSPITALD DR., LAKELAND 31635
MANNING,DONALD H. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520
MANNING,JAMES HUNT 17 ACT SU
50 PLAZA WAY, MARIETTA 30060
MANNING,JOHANN R. 36 ACT OBG
105 BRIARCLIFF RD., WARNER ROBINS 31093
MANSBERGER,ARLIE 54 ACT GE
MCG, DEPT. SURG., AUGUSTA 30902
MANSFIELD,DONALD L. 22 ACT OBG
3576 CHAMBLEE TUCKER RD., CHAMBLEE 30341
MANSOUR,KAMAL A. 29 ACT TS
1365 CLIFTON RD. NE, ATLANTA 30322
MANUS,RICHARD CHESLEY 17 ACT FP
1668 MULKEY RD., AUSTELL 30001
MARCUCCI,MIGUEL A. 29 ACT VS
2404 AUSTELL RD., AUSTELL 30001
MARCUS,NEAL W. 29 ACT OR
1365 CLIFTON RD.,NE, ATLANTA 30322
MARCUS,ROBERT D. 47 ACT OTO
1962 NORTH AVE., COLUMBUS 31901
MARISCANO,ANTHONY R. 11 ACT FP
602 E. 67TH ST., SAVANNAH 31405
MARKHAM,JOHN C.,III 54 ACT GE
1514 ANTHONY RD., AUGUSTA 30904
MARKLE,C. DAVID 17 ACT I
2271 AUSTELL RD., AUSTELL 30001
MARKS,THOMAS W. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
MARLOW,JAMES E. 76 ACT FP
1714 CLEVELAND AVE., DALTON 30720
MARMER,ROBERT H. 29 ACT OPH
777 CLEVELAND AVE.,SW, ATLANTA 30315
MARRINER,E. F. 34 ACT OCM
CHICOPEE MFG. CO., GAINESVILLE 30501
MARSCHALK,F. F.,JR. 54 ACT I
2710 LAKEWOOD DR., AUGUSTA 30904
MARSHALL,A. SMOAK 36 ACT SU
725 N MACON ST., FORT VALLEY 31030
MARSHALL,LOUIE W. 54 ACT P
FHD,VA HOSPITAL, AUGUSTA 30904

MARTENS,LESTER J. 27 ACT I
321 W. 7TH ST., ROME 30161
MARTENSON,EDGAR 11 ACT FP
42 MEDICAL ARTS, SAVANNAH 31405
MARTIN,DAN ALLEN 13 ACT SU
P. O. BOX 347, LAWRENCEVILLE 30245
MARTIN,ELISABETH 13 ACT OBG
P. O. BOX 946, CUMMING 30130
MARTIN,H. U. 76 ACT R
P.O. BOX 1285, DALTON 30720
MARTIN,J. D.,JR. 29 A SU
230 ROBIN HOOD RD. NE, ATLANTA 30309
MARTIN,J. O. 06 ACT OPH
745 PINE ST., MACON 31201
MARTIN,JAMES B. 23 ACT OBG
707 N. JEFFERSON STREET, ALBANY 31705
MARTIN,JOHN M. 54 ACT I
1138 DRUID PARK AVE., AUGUSTA 30904
MARTIN,LEE A. 34 ACT U
290 S. ENOTA DR., GAINESVILLE 30501
MARTIN,LOUIS G. 29 ACT R
793 CLIFTON RD. N.E., ATLANTA 30307
MARTIN,ROBERT B.,III 53 ACT SU
201 RANDOLPH ST., CUTHBERT 31740
MARTIN,TALMADGE M. 10 ACT SU
619 DIXIE STREET, CARROLLTON 30117
MARTIN,WALTER D. 53 ACT FP
DAWSON 31742
MARTIN,WILLIAM O.,III 29 ACT OPH
1938 PEACHTREE RD. NW, ATLANTA 30309
MARTINEZ,A. C. 02 ACT I
P. O. BOX 677, MILLEDGEVILLE 31062
MARTINEZ,JOS. 72 ACT ANES
MEM. HOSP., WAYCROSS 31501
MARTINEZ,MARCIAL E. 56 ACT R
P. O. BOX 303, ADEL 31620
MARTYNSKI,STANISLAW 70 ACT PD
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30742
MASHBURN,JAMES S. 13 ACT SU
P. O. BOX 668, CUMMING 30130
MASHBURN,MARCUS 13 DE5 FP
P. O. BOX 668, CUMMING 30130
MASHBURN,MARCUS,JR. 13 ACT OBG
P. O. BOX 668, CUMMING 30130
MASON,EDWARD MCK. 29 ACT SU
315 BLVD. N. E. STE. 532, ATLANTA 30312
MASON,JAMES L. 22 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
MASON,M. H. 13 ACT FP
P.O. BOX 248, DULUTH 30136
MASON,W. ROY 29 ACT
EMORY UNIV. OFC. OF UNIV. PHY., ATL 30322
MASON,WILLIAM ALFRED 29 A PH
118 MARIETTA ST. NW, ATLANTA 30303
MASSEE,JOSEPH C. 29 DE5 I
21 8TH ST. N. E., ATLANTA 30309
MASSENGALE,L. R. 54 ACT PD
1903 ROCK SPRINGS DR., AUGUSTA 30904
MASSEY,JOE B. 29 ACT OBG
960 JOHNSON FERRY RD., ATLANTA 30342
MATHENY,JAMES T. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
MATHEWS,WAYNE S. 22 ACT PD
2100 PARK LAKE DR. NE, ATLANTA 30345
MATHEWS,WILLIAM H. 29 A PATH
EMORY UNIV-PATH DEPT., ATLANTA 30322
MATHIAS, PHIL A. 47 S OBG
MARTIN ARMY HOSP., FT BENNING 31905
MATHIS,ERNEST H. 14 ACT OBG
P.O. BOX 965, CANTON 30114
MATHIS,JAMES W. 56 ACT SU
209 PENDLETON DR., VALDOSTA 31601
MATHIS,MARTHA 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709
MATHIS,W. H.,JR. 17 ACT R
KENNESTONE HOSPITAL, MARIETTA 30061
MATTHEW,ROBERT A. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702
MATTHEWS,LAWRENCE P. 22 DE5 OBG
1357 OXFORD RD. NE, ATLANTA 30307

MATTHEWS,SANFORD JOHN 29 ACT PD
1938 PEACHTREE ROAD NW, ATLANTA 30309
MATTHEWS,W. FRANK 22 ACT PATH
DEKALB GENERAL HOSP., DECATUR 30030
MATTISON,RICHARD C. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
MAUGHON,BOB R. 47 ACT PN
1953 SEVENTH AVE., COLUMBUS 31904
MAUGHON,JAMES S. 29 ACT SU
300 BLVD. NE, ATLANTA 30312
MAULDIN,JOHN T. 29 ACT SU
315 BLVD. NE, #528, ATLANTA 30312
MAULDIN,JOHN W. 13 ACT FP
1081 29 HWY. S., LAWRENCEVILLE 30245
MAURIZI,CHARLES P. 06 ACT PATH
3049 MALVERN HILL DR., MACON 31201
MAXWELL,EDGAR J.,JR. 44 ACT SU
P.O. DR. 190, THOMSON 30824
MAXWELL,JAMES W. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
MAXWELL,ROBERT B. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792
MAY,ROBERT D. 17 ACT U
50 PLAZA WAY, MARIETTA 30060
MAY,STEPHEN C.,JR. 17 ACT FP
SOUTH MAIN STREET, KENNESAW 30144
MAYER,W. BREM,JR. 29 ACT N
25 PRESCOTT STREET, NE, ATLANTA 30308
MAYES,ALVA LOUIE,JR. 06 ACT PD
2009 VINEVILLE AVE., MACON 31204
MAYFIELD,GEORGE R. 54 ACT I
2247 WRIGHTSBORO RD., AUGUSTA 30904
MAYHER,WILLIAM E.,III 23 ACT NS
419 FOURTH AVE., ALBANY 31705
MAYO,EARL A.,JR 53 ACT
RICHLAND 31825
MAYO,EDWIN A. 30 ACT FP
2601 PARKWOOD DR., BRUNSWICK 31520
MAYS,ALDINE M.,JR. 16 I&R FP
P. O. BOX 598, STOCKBRIDGE 30281
MAYS,J. LAMAR 29 ACT OPH
3280 HOWELL MILL RD.,NW, ATLANTA 30327
MAYS,J. R. S. 06 DE5 P
700 SPRING ST., MACON 31201
MAZO,MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
MAZUR,W. P. 47 ACT P
P. O. BOX 6563, COLUMBUS 31907
MC ANULTY,MARTHA J. 22 ACT I
3081 MAPLE DR.,NE, ATLANTA 30305
MCALISTER,BRADWELL R. 34 ACT OR
650 BROAD ST. SE, GAINESVILLE 30501
MCALLISTER,KATHRYN 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902
MCALLISTER,ROBERT W. 06 ACT P
N. HOUSTON RD., A-1, WARNER ROBINS 31093
MCARTHUR,CHARLES E. 26 DE5 FP
CORDELE 31015
MCARTHUR,JOHN D. 57 ACT
LYONS 30436
MCBRIDE,MICHAEL T. 56 ACT OBG
P.O. BOX 2978, VALDOSTA 31601
MCBRIDE,WALTER W. 17 ACT I
52 TOWER RD., MARIETTA 30062
MCCAIN,JOHN R. 29 ACT OBG
25 PRESCOTT ST. NE, ATLANTA 30308
MCCALL,CHARLES S.,JR. 23 ACT I
412 1/2 FOURTH AVE., ALBANY 31705
MCCALL,J. T.,JR. 27 ACT SU
MCCALL CLINIC, ROME 30162
MCCARD,RAY H. 06 ACT P
596 ARLINGTON PL., MACON 31201
MCCARVER,W. C.,JR. 34 ACT FP
200 PRIOR ST. SE, GAINESVILLE 30501
MCCLARIN,WILLIAM M.,JR. 72 ACT D
202 FOLKS ST., WAYCROSS 31501
MCCLATCHEY,WM. M. 29 DE2 FP
NAS ATLANTA, ATLANTA 30060
MCCLELLAN,M.M.,JR. 16 ACT PD
1035 MAIN ST., FOREST PARK 30050
MCCLELLAND,W. SPENCE 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
MCCLINTON, JOE D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
MCCLURE,E. RUTH 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062
MCCLURE,JOHN N. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
MCCLURE,ROBERT E. 29 DE1
9201 S.W. 45TH ST., MIAMI, FLA. 33165
MCCOLLUM,R. ROY,JR. 24 ACT
BOX 356, KINGSLAND 31548
MCCOLLUM,WILLIAM 65 ACT
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
MCCORD,CLINTON D.,JR. 29 ACT OPH
3280 HOWELL MILL RD. NW, ATLANTA 30327
MCCORD,DALE L. 29 ACT R
25 PRESCOTT ST. NE, ATLANTA 30308
MCCORD,JAMES W. 54 ACT N
1514 ANTHONY RD., AUGUSTA 30904
MCCORMICK,GLENN E.,JR. 22 ACT D
755 COLUMBIA DR., DECATUR 30030
MCCOY,JOHN F. 19 ACT FP
MOULTRIE 31768
MCCOY,JOHN M. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
MCCRANIE,E. JAMES 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30902
MCCRANIE,MARTHA S. 54 ACT P
TALMADGE MEM. HOSP., AUGUSTA 30902
MCCRARY,GEORGE ALFRED 68 ACT OR
303 SMITH ST., LA GRANGE 30240
MCCROSKEY,MARION M. 29 ACT ANES
144 PONCE DE LEON AVE. NE, ATLANTA 30308
MCCRUM,B. A. 34 ACT OBG
420 E. BROAD ST., GAINESVILLE 30501
MCCUISTON,C. F. 22 ACT I
3610 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
MCCULLOUGH,RICHARD E. 11 I&R I
712 EAST 18TH ST, TIFTON 31794
MCCULLY,JAMES G. 30 ACT R
3010 HAMPTON AVE., BRUNSWICK 31520
MCCURDY,WILLIS T. 22 DE5 FP
P. O. BOX 336, STONE MOUNTAIN 30083
MCDANIEL,J. G. 29 DE5 SU
820 W. WESLEY RD. NW, ATLANTA 30327
MCDANIEL,J. STUART 29 ACT OBG
1938 PEACHTREE RD., STE. 408, ATLANTA 30309
MCDANIEL,J. Z. 23 ACT U
C & S BANK BLDG., ALBANY 31701
MCDANIEL,WILLIAM L.,JR. 76 ACT FP
1203 MEMORIAL DR., DALTON 30720
MCDAVID,WILLIAM E.,JR. 16 ACT R
P.O. BOX 21, RIVERDALE 30274
MCDEW,STEPHEN M. 11 ACT OBG
918 W. BROAD ST., SAVANNAH 31401
MCDONALD,H. P. 29 DE5 U
98 CURRIER ST. NE, ATLANTA 30308
MCDONALD,J. J. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
MCDONALD,JAMES K. 54 ACT P
3651 WHEELER RD., AUGUSTA 30904
MCDONALD,LAWRENCE P. 29 ACT U
1641 LONGWORTH BLDG, WASHINGTON, DC 20515
MCDONALD,LEWIS H. 29 ACT SU
3665 IVY RD., ATLANTA 30342
MCDONALD,R. H. 20 DE5 SU
114 LAGRANGE ST, NEWNAN 30263
MCDONALD,ROBERT L. 29 ACT P
3390 PEACHTREE RD. NE, ATLANTA 30326
MCDONOUGH,L. ALLEN 29 ACT PD
1036 LINDBERG DRIVE NE, ATLANTA 30324
MCDONOUGH,PAUL G. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902
MCDOUGALL,WM. L.,JR. 29 ACT U
3250 HOWELL MILL RD. NW, ATLANTA 30327
MCDOWELL,CHARLES W.,JR. 22 ACT OPH
542 CHURCH ST., DECATUR 30030
MCELHANNON,F. M. 15 ACT SU
740 PRINCE AVE., ATHENS 30601

MCEVER,V. W.,JR. 36 ACT SU
212 HOSPITAL DR., WARNER ROBINS 31093
MCFADDEN,I. J.,II 29 ACT P
5675 PEACHTREE-DNWOODY RD, ATLANTA 30342
MCFALL,VORIS F. 36 ACT SU
WESTVIEW DRS. BLDG., FORT VALLEY 31030
MCFARLAND,D. EDWARD 54 ACT PATH
1134 DRUID PARK AVE., AUGUSTA 30904
MCGAHEE,OLLIE O.,JR. 75 ACT FP
P. O. BOX 937, JESUP 31545
MCGAHEE,ROBERT C. 54 ACT PD
1429 GWINNETT ST., AUGUSTA 30902
MCGARITY,S. S.,JR. 54 ACT P
1423 HARPER ST., AUGUSTA 30904
MCGARITY,WM. C. 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
MCGEARY,W. C.,JR. 49 ACT FP
167 W. JEFFERSON ST., MADISON 30650
MCGEE,HARRY H.,JR. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
MCGEE,THEODORE J. 47 ACT SU
ST. FRANCIS MED. PK., COLUMBUS 31904
MCGEHEE,JOHN M. 27 DE1 SU
BOX 277, CEDARTOWN 30125
MCGHEE,EARL T. 76 ACT FP
1012 BURLEYSON DR., DALTON 30720
MCGINNIS,LAMAR S.,JR. 22 ACT SU
365 WINN WAY, DECATUR 30030
MCGINTY,A. PARK 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
MCGINTY,W. R. 19 ACT SU
MOULTRIE 31768
MCGOLDRICK,THOMAS A.,JR 11 ACT I
15 E. GORDON ST., SAVANNAH 31401
MCGOOGAN, M.T. 72 ACT SU
1921 ALICE ST., WAYCROSS 31501
MCGRAW,WALKER C. 29 ACT SU
4555 N. SHALLOWFORD RD., ATLANTA 30341
MCGUIRE,JAMES E. 17 ACT OBG

MCKEE,DAVID S. 29 ACT PD
3312 PIEDMONT AVE,NE, ATLANTA 30305
MCKEMIE,W. FRANK 23 ACT
108 N. MONROE ST., ALBANY 31701
MCKENZIE,DONALD J. 65 ACT U
935 S. BROAD ST., THOMASVILLE 31792
MCKENZIE,WM. J.,JR. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
MCKINNEY,ALEXANDER S. 29 ACT N
1365 CLIFTON RD. NE, ATLANTA 30322
MCKINNEY,JAMES E. 76 ACT U
1109 BURLEYSON DRIVE, DALTON 30720
MCKINNEY,RAY L. 23 ACT R
P.O. BOX 1924, ALBANY 31702
MCKINNON,FRANK W. 17 ACT OR
652 CHURCH ST., MARIETTA 30060
MCKNIGHT,ROBERT R. 54 ACT OR
1417 GWINNETT ST., AUGUSTA 30902
MCLAIN,E.K. 54 DE5 I
905-15TH STREET, AUGUSTA 30904
MCLANE,JOHN E. 22 ACT OBG
365 WINN WAY, DECATUR 30030
MCLAREN,JOHN R. 02 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
MCLARTY,WILLIAM T.,JR. 29 ACT P
1970 CLIFF VALLEY RD. NE, ATLANTA 30329
MCLEAN,DONALD C. 29 ACT AL
1938 PEACHTREE RD. NW, ATLANTA 30309
MCLEAN,FREDERICK L. 79 ACT FP
407 MCPHAUL ST., SYLVESTER 31791
MCLEAN,WM. R. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
MCLENDON,F. EARL 29 ACT FP
75 PIEDMONT AVE. NE, ATLANTA 30303
MCLENDON,HAROLD L. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
MCLENDON,JOE L. 06 ACT OPH
P. O. BOX 956, MACON 31202
MCLENDON,JULIAN K. 10 ACT
405 ALABAMA AVENUE, BREMEN 30110
MCLENDON,REMBERT L. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701
MCLEOD,JOHN W. 19 ACT SU
223 S. MAIN ST., MOULTRIE 31768
MCLEOD,WALLACE N. 29 ACT D
340 BOULEVARD NE, ATLANTA 30312
MCMICHAEL,ROBERT S. 06 ACT
2869 NAPIER AVE., MACON 31204
MCMILLAN,E. C.,JR. 06 ACT SU
670 NEW ST., MACON 31201
MCMILLIAN,JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161
MCMURRAY,ARTHUR A. 16 ACT SU
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
MCNAIR,HAL 21 ACT FP
P.O. BOX 852, BAINBRIDGE 31717
MCNAIR,WILLIAM P. 57 ACT FP
SOPERTON 30457
MCNAMARA,VIRGINIA P. 54 ACT OBG
MEDICAL COLL. OF GA., AUGUSTA 30902
MCNATT,EUGENE N. 47 S PATH
MARTIN ARMY HOSPITAL, FT. BENNING 31905
MCNEELY,HENRY H. 60 ACT FP
TOCCOA 30577
MCNEILL,A. A.,JR. 46 ACT
CAMILLA 31730
MCNIECE,ESTELLE 29 DE5 PD
11 SEVENTEENTH ST. NE, ATLANTA 30309
MCNINCH,JOSEPH H. 29 A ACM
4565 ANGELO DR. NE, ATLANTA 30319
MCPHEETERS,HAROLD L. 29 ACT P
130 SIXTH ST. NW, ATLANTA 30313
MCPHERSON,JOHN H. T. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
MCRAE,A.T.,JR 18 ACT SU
1004 W. WARD ST., DOUGLAS 31533
MCRAE,D. B. 64 ACT SU
MCRAE 31055
MCRAE,D. R.,JR. 54 ACT SU
1427 GWINNETT ST., AUGUSTA 30902
MCREYNOLDS,B. A. 11 ACT SU
224 E. 46TH ST., SAVANNAH 31405
MCWHIRTER,WILLIAM P. 47 ACT

MEACHAM,JACK R. 27 ACT FP
P. O. BOX 160, SUMMERVILLE 30747
MEADERS,HENRY D. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060
MEADORS,JASON LAWRENCE 56 ACT R
P. O. BOX 2254, VALDOSTA 31601
MEADOWS,CARTER LEE 25 ACT SU
P. O. BOX 879, SWAINSBORO 30401
MEADOWS,NOAH D.,JR. 17 ACT I
52 TOWER RD., MARIETTA 30060
MEALING,H. G. 54 DE5 I
301 SOUTHERN FINANCE BLDG., AUGUSTA 30902
MEDINA,LEONARDO H. 16 ACT U
217 ARROWHEAD BLVD., JONESBORO 30236
MEEHAN,PETER L. 29 DE4 OR
13913 FLINT ROCK RD., ROCKVILLE, MD. 20853
MEEKS,CALVIN STEWART,JR 18 ACT FP
DOUGLAS 31533
MEEKS,WILLIAM H. 54 ACT NS
1140 DRUID PARKS AVE., AUGUSTA 30902
MEIER,JOHN A. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701
MEINE,FREDERICK J. 47 ACT R
1515 DARTMOUTH RD., COLUMBUS 31902
MELTZER,HAROLD D. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344
MELVIN,PERRY D. 36 ACT FP
124 HOSP. DR., WARNER ROBINS 31093
MENDELOFF,JOSEPH 29 S PATH
1670 CLAIRMONT RD. NE, DECATUR 30033
MENDEZ,SALVADOR A. 02 ACT P
1006 RIVERBEND DR., MILLEDGEVILLE 31061
MENENDEZ,JACK F. 06 ACT SU
700 SPRING ST., MACON 31201
MERLIN,HARVEY E. 29 ACT U
2788 BAYARD ST., ATLANTA 30344

MERREN,DAVID D. 23 ACT U
802 N. JEFFERSON, ALBANY 31705
MERRILL,ARTHUR J. 29 ACT I
35 COLLIER RD.,NW, ATLANTA 30309
MERRILL,ARTHUR J.,JR. 29 ACT C
35 LINDEN AVE, ATLANTA 30308
MERRITT,CHARLES R. 10 ACT PD
107 CLINIC AVE., CARROLLTON 30117
MERRITT,GEORGE W. 57 ACT FP
300 ARLINGTON DR., VIDALIA 30474
MERRITT,HINTON J. 58 ACT FP
COLQUITT 31737
MERRITT,JAMES W. 58 DE1 FP
COLQUITT 31737
MESERVE,FRANCIS BRUCE 36 ACT
121 N. DAVIS DR., WARNER ROBINS 31093
METTS,BETTY HOGAN 06 ACT ANES
723 CAPTAIN KELL DR., MACON 31204
METTS,JAMES C. 11 DE5 I
110 W. GASTON ST., SAVANNAH 31401
METTS,JAMES C.,JR. 11 ACT I
110 W. GASTON ST., SAVANNAH 31401
METZGER,C. ROBERT,JR. 22 ACT PD
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084
MEYER,BERNARD C. 54 ST

MICHAELS,JOHN 22 ACT PD
2100 PARK LAKE DR. NE, ATLANTA 30329
MICKEL,CAREY A.,JR. 12 ACT SU
35-7 CHESTNUT ST., ELBERTON 30635
MIDDLEBROOKS,T. W. 44 ACT FP
THOMSON 30824
MIDDLETON,FRANK F.,III 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31701
MIDDLETON,MILTON G. 65 ACT
MENTAL HEALTH CENTER, THOMASVILLE 31792
MIHALOUITS,KARL S. 17 ACT P
3188 ATLANTA ST., SMYRNA 30080
MIKELL,JOEL E. 20 ACT R
BOX 981, NEWNAN 30263
MILES,MARILYNN L. 36 ACT PD
140-C HOSPITAL DR., WARNER ROBINS 31093
MILLEDGE,ROBERT D. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
MILLER,ABRAHAM 54 ACT OBG
1270 MERRY STREET, AUGUSTA 30904
MILLER,CECIL L. 13 ACT
BUFORD MEDICAL CLINIC, BUFORD 30518
MILLER,CHESTER O. 22 ACT P
1970 CLIFF VALLEY WAY, ATLANTA 30322
MILLER,FRANK R. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792
MILLER,GAIL D. 54 ACT EM
1350 WALTON WAY, AUGUSTA 30904
MILLER,GEORGE D. 29 ACT D
275 CARPENTER DR. NE, ATLANTA 30328
MILLER,GORDON C. 47 ACT I
2300 MANCHESTER X-WAY, COLUMBUS 31904
MILLER,J. M. 56 ACT OBG
2307 N. PATTERSON ST., VALDOSTA 31603
MILLER,JOSEPH I. 29 ACT C
25 PRESCOTT ST. N. E., ATLANTA 30308
MILLER,LILA BONNER 29 ACT I
768 JUNIPER STREET NE, ATLANTA 30308
MILLER,PRESTON R. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
MILLER,ROBERT E. 75 ACT
166 MEMORIAL DR., JESUP 31545
MILLER,WILLIAM A. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
MILLER,WILLIAM S. 76 ACT FP
1800 OAKMONT DR., DALTON 30720
MILSAP,JAMES H.,JR. 22 ACT R
2910 N. DRUID HILLS RD., ATLANTA 30329
MIMS,GEO. T.,JR. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062
MIMS,OSCAR M. 65 ACT I
THOMASVILLE 31792
MINOR,B. DONALD 22 ACT R
2256 SAGAMORE HILLS DR., DECATUR 30033
MINOR,H. W. 29 DE5 I
4665 PEACHTREE DUNWOODY RD., ATLANTA 30342
MINOR,JAMES B. 29 ACT I
960 JOHNSON FERRY RD. N.E., ATLANTA 30342
MINTER,BRENDA B. 54 ACT
BOX 55, GRACEWOOD 30812
MITCHELL,ALEX R. 06 ACT PATH
MEDICAL CENTER OF CENTRAL GA., MACON 31208
MITCHELL,CHARLES H. 54 R ANES
MEDICAL COLLEGE OF GA., AUGUSTA 30902
MITCHELL,FRANK B.,JR. 30 ACT SU
3011 KEMBLE AVENUE, BRUNSWICK 31520
MITCHELL,J. T. 68 ACT R
CITY-COUNTY HOSPITAL, LAGRANGE 30240
MITCHELL,JAMES K.,JR. 29 ACT ALR
6075 ROSWELL RD. NW, ATLANTA 30328
MITCHELL,MARVIN A. 29 ACT SU
3250 HOWELL MILL RD., ATLANTA 30327
MITCHELL,MARVIN M. 17 ACT OR
3910 AUSTELL RD., AUSTELL 30001
MITCHELL,OTIS C. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236
MITCHELL,P. ROBERT 17 ACT OBG
653 CHEROKEE ST. N.E., MARIETTA 30060
MITCHELL,W. C. 17 ACT FP
SMYRNA 30080
MITCHELL,WM. E. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
MITCHELL,WM. E.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
MITCHENER,J. W. 54 ACT PATH
UNIVERSITY HOSP., AUGUSTA 30902
MIXON,GEORGE E. 05 ACT FP
BOX 246, OCILLA 31774
MIXSON,E. HARRY 56 ACT
DOCTORS BLDG., VALDOSTA 31603
MIXSON,JOYCE F.,JR. 56 ACT OBG
105 DOCTORS BUILDING, VALDOSTA 31603
MOKAL,ALBERT J. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30309
MOLKNER,KENNETH C. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
MOLNAR,EDMUND M. 47 ACT SU
101 DOCTORS BLDG., COLUMBUS 31901
MOLYNEAUX,E. W. 68 ACT FP
HAMMETT BLDG., LAGRANGE 30240
MONCRIEF,W. M. 29 DE5 FP
3293 HUNTERDON WAY-SOMERSET, MARIETTA 30062
MONFORT,JOHN M. 29 DE5 I
HILTON HEAD IS.,SC 29928
MONTANA,EDUARDO 27 ACT
302 W. 6TH ST., ROME 30161
MONTERO,ENRIQUE 59 ACT ANES
546 S. 8TH ST., GRIFFIN 30223
MONTES,ISMAEL G. 58 ACT SU
1605 SHOTWELL ST., BAINBRIDGE 31717
MONTGOMERY,R. C.,II 61 ACT
BUTLER 31006
MONTGOMERY,THOMAS A. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
MOODY,RAYMOND A. 06 ACT FP
755 ORANGE ST., MACON 31201
MOODY,RICHARD A. 75 ACT
P. O. BOX 456, JESUP 31545
MOON,ELLIOTT C. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084
MOONEY,A. JOHN 08 ACT
P. O. BOX 527, STATESBORO 30458
MOORE,B. WALDO,JR. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
MOORE,C. W. C. 27 ACT I
304 E. 2ND. AVE., ROME 30161
MOORE,CHARLES R. 19 ACT OPH
1303 FOURTH ST. SW, MOULTRIE 31768
MOORE,CLIFF,JR. 27 ACT SU
P.O. BOX 1108, ROME 30161
MOORE,G. RICHARD 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
MOORE,HAYWOOD L. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520

MOORE,MEL T. 22 ACT
3646 MARKET ST., CLARKSTON 30021
MOORE,PERRY 02 ACT R
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061
MOORE,RICHARD W. 11 ACT FP
905 MONTGOMERY ST., SAVANNAH 31401
MOORE,VICTOR AUGUSTUS 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
MOORE,W. L. 27 DE4

MOORE,W. W. 29 ACT NS
1175 PEACHTREE ST. NE, ATLANTA 30309
MOORE,WILLIAM L. 54 ACT I
VA HOSP., F-D-H, AUGUSTA 30904
MOORES,RUSSELL R. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
MOORHEAD,CHRISTIAN R. 29 ACT OBG
75 PIEDMONT AVE. NE, ATLANTA 30303
MOORMAN,CLAUDE T.,II 11 ACT ANES
P.O. BOX 1331, SAVANNAH 31402
MOORMAN,LARRY R. 18 ACT OPH
221 SHIRLEY AV., DOUGLAS 31533
MORAN,MARTIN J. 29 ACT PD
275 CARPENTER DR. NE, ATLANTA 30328
MORELAND,C. C. 71 ACT
WALTON CLINIC, MONROE 30655
MORELAND,ROBERT H.,JR. 11 ACT FP
709 BONNYRIDGE RD, PT. WENTWORTH 31407
MORENO, HUGO S. 29 ACT OBG
2750-A FELTON DR., EAST POINT 30344
MORETZ,WILLIAM H. 54 ACT SU
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902
MORGAN,DAVID L. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
MORGAN,FRANK E.,JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
MORGAN,HARVEY V. 11 ACT FP
1805 ABERCORN ST., SAVANNAH 31401
MORGAN,HORACE L. 29 ACT IND

MORGAN,J. C. 68 DE5 SU
WEST POINT 31833
MORGAN,JAMES C.,III 68 ACT OPH
303 SMITH ST., LAGRANGE 30240
MORGAN,JAMES C.,JR. 68 ACT OALR
P. O. BOX 590, WEST POINT 31833
MORGAN,JAMES W. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
MORGAN,MARY E. 54 ACT I
VA HOSPITAL, AUGUSTA 30904
MORGAN,ROBERT T. 79 ACT FP
501 WESTBERRY ST., SYLVESTER 31791
MORGAN,TOBBY S. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
MORGAN,Z. V.,JR. 22 ACT I
542 CHURCH ST., DECATUR 30030
MORRIS,A. J. 36 ACT SU
MONTEZUMA 31063
MORRIS,ALBERT L. 29 ACT FP
65 W. CAMPBELLTON, FAIRBURN 30213
MORRIS,LARRY A. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
MORRISON,CHARLES W. 11 ACT PL
11 MEDICAL ARTS CTR., SAVANNAH 31405
MORRISON,JOSEPH V.,JR. 11 ACT PD
4 MEDICAL ARTS CTR., SAVANNAH 31405
MORRISON,WILLIAM N. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
MORSE,CHESTER W. 22 ACT I
711 CHURCH STREET, DECATUR 30030
MORTON,JOHN B. 42 ACT I
V. A. CENTER, DUBLIN 31021
MORTON,WILLIAM J. 29 ACT U
3646 CHAMBLEE TUCKER RD., CHAMBLEE 30341
MORTON,WM. J. 65 ACT FP
S. BROAD ST., CAIRO 31728
MOSELEY,TEDDY C. 22 ACT OBG
365 WINN WAY, DECATUR 30030
MOSELEY,THOMAS H. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603
MOSLEY,H.G. 29 DE5 OBG
3514 NANCY CREEK RD., ATLANTA 30327
MOSS,BENJAMIN F.,JR. 54 ACT PN
UNIVERSITY HOSPITAL, AUGUSTA 30902
MOSS,T. H. 27 ACT OBG
409 S. BROAD STREET, ROME 30161
MOSS,THOMAS H.,JR. 27 ACT FP
409 S. BROAD ST., ROME 30161
MOSTELLAR,MARVOUS E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
MOUSSAKHANI,JOSEPH 22 ACT OBG
3041 ACCESS RD. NE EXP., CHAMBLEE 30341
MOYE,BEN H. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601
MOYE,R. J. 25 ACT FP
SWAINSBORO 30401
MOYER,LEROY N. 29 ACT OBG
1175 PEACHTREE ST. NE, ATLANTA 30309
MULHERIN,C. S. 54 ACT SU
1527 GWINNETT ST., AUGUSTA 30904
MULHERIN,JOSEPH A. 11 ACT ANES
711 E. 44TH ST., SAVANNAH 31405
MULHERIN,JOSEPH L. 54 ACT SU
1467 HARPER ST., AUGUSTA 30902
MULHERIN,WILLIAM B. 15 ACT OR
125 KING AVE., ATHENS 30601
MULKEY,A. P. 08 ACT SU
110 E. COLLEGE AVE., MILLEN 30442
MULLER,GERALD B. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
MULLINIKS,ROBERT C.,JR. 17 ACT OBG
2404 AUSTELL RD., AUSTELL 30001
MULLINS,SPENCER G. 17 ACT SU
605 CAMPBELL HILL ST., MARIETTA 30062
MULLINS,WM. BERNARD 54 ACT PATH
1467 HARPER ST., AUGUSTA 30902
MULLIS,KENNETH L. 42 ACT FP
309 BELLEVUE AVE., DUBLIN 31021
MUNN,E. K. 47 DE5 OBG
2919 HAMILTON RD., COLUMBUS 31904
MUNNA,JOHN C. 29 ACT PL
3316 PIEDMONT RD. NE, ATLANTA 30305
MUNOZ,JUANA L. 29 ACT PD
1100 CLEVELAND AVE., EAST POINT 30344
MUNSAYAC,LUMAWIG Y. 64 ACT FP
BOX 487,MAIN ST., LUMBER CITY 31549
MURDOCK,ROBERT N. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
MURPHEY,ALEX T. 54 ACT I
1134 DRUID PARK AVENUE, AUGUSTA 30904
MURPHY,FRED E.,JR. 65 ACT OR
THOMASVILLE 31792
MURPHY,HARVEY J. 11 ACT SU
702 E. 66TH ST., SAVANNAH 31405
MURPHY,MICHAEL J. 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904
MURPHY,MICHAEL V.,JR. 29 ACT I
21 8TH ST. NE, ATLANTA 30309
MURPHY,RALPH A.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
MURPHY,WILLIAM R. 54 ACT PATH
P.O. BOX 694, AIKEN, S. C. 29801
MURRAY,B. LAMAR 09 ACT
FOURTH ST., WAYNESBORO 30830
MURRAY,DARRELL W. 17 ACT FP
355 OLD POWDER SPRINGS RD, MABLETON 30059
MURRAY,DOUGLAS R. 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
MURRAY,HAMIL 34 ACT PATH
HALL COUNTY HOSPITAL, GAINESVILLE 30501
MURTHY,B. R. KRISHNA 19 ACT I
GRANT PLAZA, MOULTRIE 31768
MUSARRA,E. A. 17 ACT FP
220 CHURCH ST., MARIETTA 30060
MUSARRA,E.A.,II 17 ACT PL
5419 CAROLINE, HOUSTON, TX 77004
MUSE,A. D.,JR. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
MUSHET,G. R. 54 ACT N
1003 CHAFEE AVE., AUGUSTA 30901

MUSSER,ELLYN Z. 17 ACT PD
2480 WINDY HILL RD,SE,303, MARIETTA 30062
MYERS,ALBERT A. 13 ACT FP
51 S. PTREE ST., NORCROSS 30771
MYERS,JAMES S. 76 ACT R
P. O. BOX 1285, DALTON 30720

N

NADAL,GUILLERMO 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
NAHMIAS,ANDRE J. 29 A PD
69 BUTLER ST. SE, ATLANTA 30303
NAIB,Z. M. 22 ACT PATH
80 BUTLER ST. SE, ATLANTA 30303
NAIK,MADHAV V. 68 ACT SU
ENOCH CALLAWAY CANCER CN, LAGRANGE 30240
NAMER,JOSE B. 16 ACT FP
259 ARROWHEAD BLVD., JONESBORO 30236
NANCE,DANA W. 17 ACT SU
142 COUNTRY CLUB DR., NEW ORLEANS, LA 70124
NAPOLI,VICTOR M. 29 ACT PATH
80 BUTLER ST. SE, ATLANTA 30303
NASH,D. A. 11 ACT FP
5720 COLONIAL DR., SAVANNAH 31406
NASH,H. E.,SR. 29 DE5 FP
982 SIMPSON ST.,NW, ATLANTA 30314
NASSAR,G. F. 29 ACT OBG
2739 FELTON DR., EAST POINT 30344
NATHAN,DANIEL E. 36 ACT FP
FORT VALLEY 31030
NATION,THOMAS C. 56 ACT PATH
P.O. BOX 2658, VALDOSTA 31601
NAZLI,MEHMET H. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
NEAL,JULE C.,JR. 06 ACT OBG
380 HOSP. DR., MACON 31201
NECHTMAN,CARL M. 54 ACT OALR
1511 ANTHONY RD., AUGUSTA 30904
NEEL,JULIAN B. 65 ACT SU
207 E. JACKSON ST., THOMASVILLE 31792
NEELD,JOHN B. 29 ACT ANES
2620 MEADOWLAWN DR., MARIETTA 30062
NEELY,F. LEVERING 29 ACT I
35 COLLIER RD.,NW, ATL 30309
NEIGHBORS,J. B.,JR. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
NEISTADT,ARNOLD 17 ACT SU
2550 WINDY HILL RD., MARIETTA 30062
NELKEN,VIOLA D. 47 ACT ANES
DOCTORS BUILDING, COLUMBUS 31901
NELSON,ELLIS H. 54 ACT R
1467 HARPER ST., AUGUSTA 30902
NELSON,FRED L.,JR. 56 ACT R
P.O. BOX 308, NASHVILLE 31639
NELSON,GEORGE H. 54 ACT OBG
MED. COLLEGE OF GA., AUGUSTA 30902
NELSON,HOMER S. 06 ACT OPH
BOX 956, MACON 31202
NELSON,JOHN W. 56 ACT PATH
P.O. BOX 1727, VALDOSTA 31601
NELSON,MAYNARD 54 ACT SU
1502 ANTHONY RD., AUGUSTA 30904
NESBITT,ROBERT R.,JR. 54 ACT SU
MED. COLLEGE OF GA, AUGUSTA 30902
NETTLES,JOE L. 11 ACT OR
P. O. BOX 6156, SAVANNAH 31405
NEUBERG,S. CHARLOTTE 06 ACT
608 AMERICAN FEDERAL BLDG., MACON 31201
NEUFELD,JOCELYN R. 15 ACT ANES
135 GATEWOOD PL., ATHENS 30601
NEVILLE, R L 11 DE5 SU
2115 BULL STREET, SAVANNAH 31401
NEWBERRY,DAN C. 47 ACT ANES
DOCTORS BLDG., COLUMBUS 31901
NEWMAN,DONALD D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
NEWMAN,HARVEY M. 34 ACT PD
650 BROAD ST. S.E., GAINESVILLE 30501
NEWMAN,W. A. 06 DE5 OR
4-D MASSEE APTS., MACON 31201
NEWSOM,BRUCE C. 47 ACT SU
633 19TH ST., COLUMBUS 31901
NEWSOM,NEAL H. 29 ACT OBG
2045 PEACHTREE RD. NE, ATLANTA 30309
NEWTON,JOHN S. 47 ACT OPH
317 DOCTORS BLDG., COLUMBUS 30902
NEWTON,MILLEGE C. 06 ACT I
380 HOSPITAL DR., MACON 31201
NEWTON,RALPH G.,JR. 06 ACT U
718 FIRST ST., MACON 31201
NEWTON,W. M.,JR. 19 ACT I
MEDICAL CTR, THOMASVL HWY, MOULTRIE 31768
NEWTON,W. R. 06 ACT
801 SPRING ST., MACON 31201
NEWTON,Z. B.,III 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
NICHOLAS,EDMUND M. 29 ACT U
490 PEACHTREE ST.,NE,STE.141, ATLANTA 30308
NICHOLS,DAVID M. 22 ACT P
2871 CRAVEY DR., ATLANTA 30345
NICHOLS,EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060
NICHOLS,FENWICK T.,JR. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405
NICHOLS,JOSEPH J. 29 ACT PR
490 PEACHTREE ST. NE, ATLANTA 30308
NICHOLS,POMEROY 54 ACT NS
1521 POPE AVE., AUGUSTA 30904
NICHOLS,W. H. 14 ACT
110 WALESKA RD., CANTON 30114
NICHOLSON,GEORGE T. 33 ACT FP
ROUTE 1,BOX178AB, MT. AIRY 30563
NICHOLSON,W. LANIER 34 ACT FP
HIAWASSEE 30546
NICKERSON,JOHN F. 29 ACT PATH
35 LINDEN AVE. NE, ATLANTA 30308
NICOLSON,WM. P.,III 29 ACT U
35 COLLIER RD. NW, ATLANTA 30309
NILES,GEORGE A.,JR. 29 ACT OBG
1938 PEACHTREE RD. NW, ATLANTA 30309
NINCIC,ALEXANDER 29 ACT U
401 PECHTREE ST.,NE,411, ATLANTA 30308
NINO,HOMERO F. 29 S R
P. O. BOX 33325, DECATUR 30033
NIPPERT,PHILIP H. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308
NIX,DILLARD L. 15 ACT OALR
1010 PRINCE AVENUE, ATHENS 30601
NIXON,DANIEL W. 54 ACT ON
1365 CLIFTON RD,NE, ATLANTA 30322
NOBLE,CARL W. 30 A FP
BONNEVILLE, KY 41314
NOBLE,CARL W. 29 A SU
1054 N. VIRGINIA AVE.,NE, ATLANTA 30306
NODAL,RONALDO R. 22 ACT OBG
7 LA VISTA PER. OFC. PK., TUCKER 30084
NOLAN,THOMAS R. 29 ACT SU
2788 BAYARD ST., EAST POINT 30344
NORA,FELICIANO C. 27 ACT SU
FLOYD HOSP., ROME 30161
NORMAN,LEWIS G.,JR. 68 ACT SU
WEST POINT 31833
NORTH,ALVIN W. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
NORTHUP,JOHN D. 11 ACT GE
5705 PAULSEN ST., #125, SAVANNAH 31405
NORTON,R. F. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161
NORWOOD,WM. F. 29 ACT PD
3158 MAPLE DR. NE, ATLANTA 30305
NOWELL,DAVID M. 76 ACT G
P. O. BOX 1138, DALTON 30720
NUGENT,JEFFREY T. 29 ACT OR
1938 PEACHTREE RD NW #705, ATLANTA 30309
NUNEZ,WILLIAM D. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
NUTT,RICHARD L. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31603

NUTTALL,ROBERT P. 17 ACT FP
123 GORDON RD., MABLETON 30059
NUTTER,DONALD O. 29 A I
69 BUTLER ST. SE, ATLANTA 30303

O

O'MALLEY,GEOFFREY A. 54 I&R SU
MEDICAL COLLEGE OF GA, AUGUSTA 30904
OBRIEN,DAVID P. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
OBRIEN,MARK S. 29 ACT NS
1365 CLIFTON RD. NE, ATLANTA 30322
OCONNELL,MICHAEL J. 72 ACT OR
1507 ALICE ST., WAYCROSS 31501
ODANIEL,J. F. 42 R FP
107 ROWE ST., DUBLIN 31021
ODOM,HART S. 47 ACT
P.O. BOX 2299, COLUMBUS 31902
ODOM,LAWRENCE D. 11 I&R
BOX 688 STA C, SAVANNAH 31405
OFFUTT,RANDOLPH 27 ACT OPH
325 W. 9TH ST, ROME 30161
OGLESBY,JAMES W. 23 ACT TS
910 N. JEFFERSON ST., ALBANY 31705
OKEL,BENJAMIN B. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033
OKUN,PHILIP 17 I&R P

OLANSKY,MARIAN F. 29 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
OLANSKY,SIDNEY 29 ACT D
EMORY UNIV. CLINIC, ATLANTA 30322
OLDHAM,HARRY M.,JR. 54 ACT OBG
1501 ANTHONY RD., AUGUSTA 30904
OLIVEIRA,EDUARDO 24 ACT SU
%ROY MCCOLLUM,MD, KINGSLAND 31548
OLIVER,ROBERT LEE 11 DE5 SU
DE RENNE APTS., SAVANNAH 31401
OLIVER,ROBERT W.,JR. 42 ACT SU
508 ACADEMY AVE., DUBLIN 31021
OLKOWSKI,Z. L. 22 A R
WINSHIP CLN., EMORY UNIV., ATLANTA 30322
OLLER,JOSEPH L. 54 ACT ANES
812 13TH ST., AUGUSTA 30901
OLNICK,HERBERT M. 06 R R
724 HEMLOCK ST., MACON 31201
OLSON,CLYDE L. 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31406
ONEAL,BUFORD L. 29 ACT OALR
478 PEACHTREE ST. NE, ATLANTA 30308
ONEAL,JOHN B.,III 12 ACT SU
33 CHESTNUT ST., ELBERTON 30635
ONEAL,PHYLLIS J. 12 ACT I
33 CHESTNUT ST., ELBERTON 30635
ONEAL,R. S. 68 DE5 FP
LAGRANGE 30240
OOSTERHOUDT,JAMES J. 76 ACT SU
P. O. BOX 924, DALTON 30720
OQUIN,WILLIAM P. 22 ACT FP
2140 HENDERSON MILL RD., ATLANTA 30345
OQUINN,JAMES L. 54 ACT PATH
3651 WHEELER RD, AUGUSTA 30904
OREAR,HARRY B. 54 ACT PD
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
OROSZ,JUDY I. 04 ACT PD
19 NELSON ST., CARTERSVILLE 30120
ORR,WILLIAM W. 06 ACT PD
2009 VINEVILLE AVE., MACON 31204
ORTEGA,HERNANDO JOSE 29 ACT SU
2958 RAINBOW DR., DECATUR 30034
ORTIZ,JESUS 11 ACT P
5105 PAULSEN ST., SAVANNAH 31405
OSBORNE,E. S. 11 DE5 OALR
P.O. BOX 870, SAVANNAH BEACH 31328
OSBORNE,ELTON S.,JR. 29 ACT I
47 TRINITY AVE. SW, ATLANTA 30334
OSBORNE,HORACE H. 54 ACT ANES
3609 NASSAU DR., AUGUSTA 30904
OSBORNE,W. W. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
OSHAUGHNESSEY,W. JHN JR. 06 ACT I
618 ORANGE ST., MACON 31201
OSHLAG,ABRAHAM M. 59 ACT I
3175 HILL STREET, GRIFFIN 30223
OSTA,SALIM M. 30 ACT ON
520 OCEAN BLVD., ST. SIMONS IS. 31522
OSTEEN,CLARK L. 11 ACT ANES
206 W. BAY ST., SAVANNAH 31401
OTIS,JOHN B. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
OTKEN,LUTHER B.,JR. 54 ACT PATH
TALMADGE MEM. HOSP., AUGUSTA 30902
OVERTON,JOHN W.,JR. 29 ACT EM
747 STONEVIEW CT. , MARIETTA 30062
OWEN,RALPH G. 54 ACT OBG
1502 ANTHONY RD., AUGUSTA 30904
OWENS,B. G. 56 DE5 SU
111 E. ALDEN AVE., VALDOSTA 31603
OWENS,JOS. L. 30 ACT TS
3010 HAMPTON AVE., BRUNSWICK 31520
OWINGS,RICHARD S. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902
OXFORD,WILLIAM M. 69 ACT SU
405 W. MAIN ST., THOMASTON 30297
OZAWA,TAKESHI 54 ACT NE
FHD,VA HOSPITAL, AUGUSTA 30902

P

PACIFICI,JOSEPH 11 ACT FP
2 E. TAYLOR ST., SAVANNAH 31401
PACKER,ROBERT M.,JR. 72 ACT I
P.O. BOX 899, WAYCROSS 31501
PAGE,JOHN A. 06 ACT OPH
800 FIRST ST., MACON 31201
PAGSISIHAN,FRANCISCO H. 49 S SU
P.O. BOX 10, MADISON 30650
PALAY,BERNARD H. 29 ACT I
1175 PEACHTREE ST. NE, ATLANTA 30309
PALMER,E. CAPERS,JR. 29 ACT PATH
1439 EMORY RD., ATLANTA 30306
PALMER,FRED L. 17 ACT R
3865 STORY DR., MARIETTA 30060
PALMER,J. GARY,JR. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060
PALMER,JACK R. 15 ACT
1010 PRINCE AVE. #E, ATHENS 30601
PALMER,JAMES D. 29 ACT I
970 HUNTER STREET SW, ATLANTA 30314
PALMER,JOHN R. 54 ACT OR
MED. COLLEGE OF GA., AUGUSTA 30904
PARHAM,ROBERT E. 17 ACT N
670 CHEROKEE ST. NE, MARIETTA 30060
PARISH,HAVNER H.,JR. 23 ACT U

PARK,IH KOO 70 ACT SU
102 MEMORIAL MED BL, CHATTANOOGA TN 37404
PARKER,GREGG 23 ACT OBG
401-B MADISON AVE., ALBANY 31707
PARKER,J. LEE 49 ACT FP
GREENSBORO 30642
PARKER,PRENTISS E.,JR. 17 ACT OBG
3903 SOUTH COBB DR #206, SMYRNA 30080
PARKER,T. L. 18 ACT SU
DOUGLAS 31533
PARKHURST,ROBERT D. 56 ACT PD
107 WOODROW WILSON, VALDOSTA 31601
PARKS,JOSEPH W.,JR. 20 ACT FP
P. O. BOX 609, NEWNAN 30263
PARMER,KEITH M. 14 ACT FP
CANTON MED. CTR., CANTON 30114
PARNELL,R. PARKS,JR. 29 ACT FP
OAKDALE CLINIC, SMYRNA 30080
PARRISH,JOE E. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
PARRISH,ROBERT A.,JR. 54 ACT SU
TALMADGE MEM. HOSP., AUGUSTA 30902

PARRISH,WILLIAM C. 13 ACT FP
160 N. MAIN ST., ALPHARETTA 30201
PARROTT,JESSE LYLE 56 ACT FP
HAHIRA 31632
PARROTT,THOMAS S. 29 ACT U
137 DYSON DR.,NE, ATLANTA 30307
PARSONS,RICHARD C. 22 ACT ALR
755 COLUMBIA DR., DECATUR 30030
PARUNGAO,R. L. 29 ACT SU
1235 SALEN GATEWAY, CONYERS 30207
PASCHAL,J. DEAN 23 ACT PD
910 N. JEFFERSON ST., ALBANY 31705
PASCUAL,RAFAEL R. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
PASTORIUS,GEORGE J. 11 DE1 ANES
3601 BULL ST., SAVANNAH 31405
PATRICK,E. V. 10 ACT I
CARROLLTON 30117
PATRICK,JOHN W. 69 ACT R
301 CHARLES AVE., THOMASTON 30286
PATTERSON,GEORGE W. 50 ACT FP
DODGE CT. HOSP., EASTMAN 31023
PATTERSON,JOS. H. 29 ACT PD
1405 CLIFTON RD. NE, ATLANTA 30333
PATTERSON,MCLEOD 47 ACT FP
1612 ELMWOOD DR., COLUMBUS 31906
PATTERSON,SCOTT 29 ACT P
811 JUNIPER ST. NE, ATLANTA 30308
PATTERSON,WM. C. 17 ACT SU
3903 S. COBB DR., #110, SMYRNA 30080
PATTON, ROBERT M. 47 ACT C
2300 MANCHESTER XWAY, COLUMBUS 31904
PATTON,MAURICE G. 54 ACT PH
1001 BAILIE DR., AUGUSTA 30902
PATY,ROBERT M.,JR. 48 DE5 SU
P. O. BOX 527, OXFORD 30267
PAULK,E. ALAN,JR. 22 ACT I
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084
PAULK,J. R. 19 ACT OALR
1320 5TH ST.,SW, MOULTRIE 31768
PAULLIN,WM. L.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
PAULY,ROBERT P. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
PAUSA,SERGIO G. 17 ACT SU
123 GORDON RD., MABLETON 30059
PAYNE,FRANKLIN E.,JR. 54 ACT FP
MEDICAL COLLEGE OF GA, AUGUSTA 30902
PAYNE,JOHN F. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792
PAYNE,NETTLETON S. 29 ACT N
1365 CLIFTON RD. NE, ATLANTA 30322
PAYNE,PAUL J. 17 ACT OR
652 CHURCH ST., MARIETTA 30060
PAYNE,PETER M. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PAYNE,R. F. 54 ACT PH
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
PAYNE,ROBERT A. 15 ACT U
195 KING AVE., ATHENS 30601
PAYNE,WOODROW W. 30 ACT U
SHRINE RD., BRUNSWICK 31520
PEACOCK,LAMAR B. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
PEACOCK,RAY LOWELL,JR. 34 ACT PD
274 ENOTA DR. NE, GAINESVILLE 30501
PEACOCKE,IVAN L. 29 ACT PATH
35 LINDEN AVE. NE, ATLANTA 30322
PEARCE,T. ELDER,JR. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PEEK,STANLEY L.,JR 29 ACT SU
1935 HOWELL MILL RD.,NW, ATLANTA 30318
PEIKEN,ALAN S. 47 ACT I
102 DOCTORS BLDG., COLUMBUS 31901
PEIRCE,KENNETH E. 47 ACT AL
MEDICAL ARTS BLDG., COLUMBUS 31901
PENA,LEOPOLD I. 17 ACT SU
3812 AUSTELL RD., MARIETTA 30060
PENCE,ROBERT L. 08 ACT
P. O. BOX 388, METTER 30439
PENDERGRAST,WM. J. 29 ACT SU
478 PTREE ST., NE, ATLANTA 30308
PENNINGTON,CLAUDE LEE 06 ACT ALR
800 FIRST STREET, MACON 31201
PENNINGTON,E. EARL 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PENNINGTON,JOHN A. 17 ACT ANES
3312 BUNKER HILL DR., MARIETTA 30062
PENTECOST,MARK P. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
PEPIN,HENRY S. 65 ACT FP
602 E. SEIXAS ST., THOMASVILLE 31792
PER-LEE,JOHN H. 29 ACT ALR
EMORY UNIV. CLINIC, ATLANTA 30322
PERDOMO,ROBERTO R. 02 ACT FP
STATE HOSP., MILLEDGEVILLE 31061
PERDUE,GARLAND D.,JR. 29 ACT SU
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PEREA,JAIME 24 ACT P
1205 N. THIRD STREET, FOLKSTON 31537
PEREZ,A. R. 29 ACT SU
1311 CLEVELAND AVE., EAST POINT 30344
PEREZ,JUAN 02 ACT
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
PERKINS,G. E.,II 27 ACT PUL
HORSELEG ESTATES, ROME 30163
PERKINS,H. R. 54 DE1 OALR
P. O. BOX 3583, AUGUSTA 30904
PERKINS,J. MORRIS 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
PERKINS,JACK B. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
PERKINSON,NEIL G. 29 ACT SU
384 PEACHTREE ST. NE, ATLANTA 30308
PERLING,DAVIS S. 29 ACT I
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
PERROW,G. H. 14 ACT FP
JASPER 30143
PERRY,ROBERT E.,JR. 30 ACT PATH
P. O. BOX 1333, BRUNSWICK 31521
PERSALL,JOHN T. 54 ACT OBG
1280 MERRY STREET, AUGUSTA 30904
PESKIN,HERMAN 54 ACT I
1134 DRUID PARK AVE., AUGUSTA 30904
PESSOLANO,L. C. 54 ACT FP
2307 MARVIN PLACE, AUGUSTA 30906
PESZCZYNSKI,MIECZYSLAW 29 DE1 PM
80 BUTLER ST. SE, ATLANTA 30303
PETERS,HANS J. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31904
PETERS,JAMES S. 56 ACT R
4513 CLUB CIR. NE, ATLANTA 30319
PETERS,MARGARET P. 29 S ANES
1670 CLAIRMONT RD. NE, ATLANTA 30329
PETERSON,T. A. 11 ACT FP
P.O. BOX 130, AILEY 31410
PETRIE,LESTER M. 29 DE1 PH
304 WILTON DR., DECATUR 30030
PETTIT,MANSON B. 65 ACT P
TUXEDO DR., THOMASVILLE 31792
PEYTON,RICHARD R. 06 ACT OBG
856 1ST ST., MACON 31201
PHELPS,PAUL R. 06 ACT SU
781 SPRINGS ST., MACON 31201
PHILLIPS,A. M.,JR. 06 ACT OR
380 HOSPITAL DR., MACON 31201
PHILLIPS,ANDRO P. 11 ACT FP
323 EAST JONES STREET, SAVANNAH 31401
PHILLIPS,CHARLES D. 29 ACT OR
607 HOLCOMB BRIDGE RD., ROSWELL 30075
PHILLIPS,JAMES E. 06 ACT PATH
4946 BRITTANY DR., MACON 31204
PHILLIPS,JOE M.,JR. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
PHILLIPS,THOMAS W. 29 ACT R
25 PRESCOTT ST., ATLANTA 30308
PHINIZY,IRVINE 54 DE5 I
SOU. FINANCE BLDG., AUGUSTA 30902
PHINIZY,JOHN 54 ACT I
3651 WHEELER RD., AUGUSTA 30904

PHRYDAS,IRENE A. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
PIATT,EDWARD D. 11 ACT R
9 MEDICAL ARTS CTR., SAVANNAH 31405
PICKENS,JAMES C. 60 ACT OBG
800 E DOYLE ST., TOCCOA 30577
PIERCE,LARRY H. 54 ACT D
1422 GWINNETT ST., AUGUSTA 30902
PIERCE,MART T. 30 ACT FP
P. O. BOX 1003, BRUNSWICK 31520
PIEROTTI,JULIUS V. 29 DE1 FP
2407 E. CLUB DR. NE, ATLANTA 30319
PIKE,BENJAMIN F. 47 ACT I
COLUMBUS MEDICAL CENTER, COLUMBUS 31902
PIKE,BENJAMIN L. 11 ACT I
32 MEDICAL ARTS CENTER, SAVANNAH 31405
PILCHER,B. LAMAR 36 ACT R
HOUSTON CT. HOSP., WARNER ROBINS 31093
PILCHER,JAMES W. 39 ACT I
512 W. 8TH ST., LOUISVILLE 30434
PINSON,HARRY D. 54 ACT SU
3412 WALTON WAY, AUGUSTA 30904
PIRKLE,CECIL H. 29 ACT SU
1311 CLEVELAND AVE., EAST POINT 30344
PIRKLE,QUENTIN 26 ACT SU
P.O. BOX 10007, ATLANTA 30319
PIRKLE,T. N. 26 ACT R
P.O. BOX 1002, CORDELE 31015
PITTARD,M. D. 60 ACT FP
TOCCOA 30577
PITTMAN,CARL S. 66 DE5
TIFTON 31794
PITTMAN,CARL S.,JR. 66 ACT FP
TIFTON 31794
PITTMAN,FRANK S.,III 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PLAUTH,WILLIAM H.,JR. 29 ACT PDC
1365 CLIFTON RD. NE, ATLANTA 30322
PLINKE,ROBERT W. 07 ACT FP
HWY 5, SOUTH, ELLIJAY 30540
PODOBNIKAR, MICHAEL F. 16 ACT SU
P.O. BOX 335, STOCKBRIDGE 30281
POLIAKOFF,SAMUEL R. 29 ACT OBG
3290 HOWELL MILL RD,NW,321, ATLANTA 30327
POLITSOS,MICHAEL J. 29 ACT SU
35 LINDEN AVE. NE, ATLANTA 30308
POLLARD,ZANE F. 29 ACT OPH
575 W. PTREE ST. NE, ATLANTA 30308
POLLOCK,CHARLES E. 78 ACT SU
WASHINGTON 30673
POLLOCK,JOHN EDWARD JR. 78 ACT FP
GORDON ST., WASHINGTON 30673
POMEROY,W. L. 72 DE5 SU
WAYCROSS 31501
POMEROY,WILLIAM L.,JR. 72 ACT I
410 ZACHRY STREET, WAYCROSS 31501
PONCE DE LEON,A. I. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
POOL,LELAND L. 34 ACT ANES
HALL CO. HOSPITAL, GAINESVILLE 30501
POOL,WINFORD H.,JR. 54 ACT R
TALMADGE MEM. HOSP., AUGUSTA 30902
POOLE,ROBERT NEIL 29 ACT PD
5675 PTREE-DUNWOODY, ATLANTA 30342
POOLE,SAMUEL O. 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
POPE,ROY JR. 70 ACT FP
CHICKAMAUGA 30707
PORTER,HARRY,JR. 17 ACT P
3188 ATLANTA RD. SE, SMYRNA 30080
PORTER,JOHN E. 11 ACT FP
5105 PAULSEN ST., SAVANNAH 31405
PORTER,MAC W. 29 ACT FP
4575 N. SHALLOWFORD RD., ATLANTA 30341
PORTH,EDNA S. 29 ACT FP
3130 MAPLE DR. NE, ATLANTA 30305
PORTILLO,LORENZO A. DEL 02 ACT P
P.O. BOX 507, HARDWICK 31034
PORTMAN,H. J. 11 ACT PD
118 E. 34TH ST., SAVANNAH 31401
PORUBSKY,EDWARD S. 54 ACT OTO
MEDICAL COLLEGE OF GA., AUGUSTA 30902
POTITONG,BANLU 69 ACT I
405 W. MAIN ST, BOX 752, THOMASTON 30286
POTITONG,PRATOOM 69 ACT PD
405 W. MAIN ST, BOX 752, THOMASTON 30286
POU,LEO H.,JR. 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
POUND,EDWIN C.,JR. 29 ACT PL
35 COLLIER RD. NW, ATLANTA 30309
POUND,WILLIAM E. 06 ACT FP
670 NEW STREET, MACON 31201
POWELL,BARBARA A. 54 ACT OBG
MEDICAL VILLAGE, AUGUSTA 30904
POWELL,F. C. 22 ACT I
3307 WILTSHIRE DR., AVONDALE ESTATES 30002
POWELL,JACK H.,JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263
POWELL,JOHN E.,JR. 10 ACT FP
VILLA RICA 30180
POWELL,MATTHEW J. G. 06 ACT FP
MEDICAL CENTER OF CENTRAL GA., MACON 31204
POWELL,RALPH W. 22 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
POWERS,LEANDER K. 11 ACT FP
29 E. JONES ST., SAVANNAH 31401
PRADA,OSCAR 42 ACT FP
112 ROWE ST., DUBLIN 31021
PRATER,R. BURT,JR. 22 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30341
PRATHER,STUART H.,JR. 54 ACT R
3623 J. DEWEY GRAY CIRCLE, AUGUSTA 30904
PREEDY,JOHN R. K. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
PRICE,NORMA A. 29 ACT I
5675 P'TREE-DNWDY RD,NE, ATLANTA 30342
PRICE,QUENTIN 42 ACT FP
205 W. GAINES ST., DUBLIN 31021
PRIETO,EDWARD A. 66 ACT ANES
P.O. BOX 132, TIFTON 31794
PRIM,CARY J. 06 ACT ANES
1860 FLINTWOOD DR., MACON 31201
PRINCE,ALAN D. 17 ACT N
50 PLAZA WAY, MARIETTA 30060
PRINCE,RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
PRINTZ,DON W. 22 ACT D
4303 LAVISTA RD., TUCKER 30084
PRITCHETT,JOHN H.,JR. 10 ACT
BREMEN 30110
PRITZKER,MARTIN S. 11 ACT D
P. O. BOX 13603, SAVANNAH 31406
PROCHNICKI,LOUIS J. 17 ACT OBG
3910 AUSTELL RD., AUSTELL 30001
PROCTOR,ROBERT F. 42 ACT I
VA CENTER, DUBLIN 31021
PRUCE,ARTHUR 29 DE1 PM
384 PEACHTREE ST.,NE, ATLANTA 30308
PRUCE,MARTA 29 ACT P
10 CARLTON DR. NW, ATLANTA 30342
PRUETT,JAMES E. 22 ACT ALR
755 COLUMBIA DR., DECATUR 30030
PRYOR,CAROL G. 54 ACT OBG
1500 JOHNS RD., AUGUSTA 30904
PUGH,JAMES W. 29 ACT FP
461 KING ARNOLD ST., HAPEVILLE 30354
PULLIAM,MORRIS M. 48 DE2 FP
RT. 4, ELIZABETH ST., COVINGTON 30209
PUMPELLY,ROBERT A. 75 ACT FP
166 MEMORIAL DR., JESUP 31545
PURCELL,BILL 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
PURCELL,J. W.,JR. 48 ACT FP
5278 ADAMS ST., COVINGTON 30209
PURKS,W. WARREN,JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
PURSLEY,NORMAN B. 54 ACT
GA. TRAINING SCHOOL, GRACEWOOD 30812
PURVIS,JERRY G. 56 ACT SU
106 W. NORTHSIDE DR, VALDOSTA 31601

Q

QUANTZ,NEWTON G.,JR. 54 ACT OTO
2283 WRIGHTSBORO RD., AUGUSTA 30904
QUARTERMAN,KEITH A. JR. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
QUATTLEBAUM,J. K. 11 DE5 SU
3701 WATERS AVE., SAVANNAH 31401
QUATTLEBAUM,J. K.,JR. 11 ACT SU
P.O. BOX 9787, SAVANNAH 31404
QUATTLEBAUM,ROBERT B. 56 ACT R
SUITE 104,DRS. BLDG., VALDOSTA 31601
QUATTLEBAUM,ROBERT,JR. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403
QUILALA,EMILIANO P. 16 ACT SU
409 ARROWHEAD BLVD BLDG C, JONESBORO 30236
QUILLIAN,WILLARD E.,III 54 ACT P
MED. COLLEGE OF GA., AUGUSTA 30902
QUINN,FRANCIS B.,JR. 29 ACT OALR
144 PONCE DE LEON AVE. NE, ATLANTA 30308
QUINONES,PEDRO P. 29 A
99 BUTLER ST. SE, ATLANTA 30303

R

RAAEN,TOM D. 22 ACT PATH
DEKALB GENERAL HOSPITAL, DECATUR 30030
RABB,FORTE C. 34 ACT D
327 NORTHSIDE DR. NW, GAINESVILLE 30501
RABB,J. L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
RABUN,J. B. 11 ACT R
311 E. HALL STREET, SAVANNAH 31401
RAGAN,KENNETH D. 17 ACT P
84 LACY ST., MARIETTA 30060
RAGHU,G.V. 36 ACT OBG
07-B N. HOUSTON RD., WARNER ROBINS 31093
RAIFORD,MORGAN B. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
RAINES,JACK A. 47 ACT P
2601 CROSS COUNTRY DR,47, COLUMBUS 31906
RAITZ,ROBERT L. 76 ACT FP
1012 BURLEYSON DR., DALTON 30720
RAMOS,FERNANDO Q. 76 ACT FP
120 WALNUT ST., CHATSWORTH 30705
RAMOS,HAROLD S. 29 ACT I
35 LINDEN AVE. NE, ATLANTA 30308
RAMSEY,JOHN E. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030
RAMSEY,SPEIR N. 11 ACT OBG
19 MED. ARTS CENTER, SAV. 31405
RAND,EDGAR O. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
RANDALL,ALFRED H.,JR. 17 ACT I
641 CHURCH ST., MARIETTA 30060
RANDALL,R. BEAUVAIS,JR. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30032
RANDO,STEPHEN 06 ACT R
752 HEMLOCK ST., MACON 31201
RANDOLPH,R. H. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
RANDOLPH,W. QUENTON 03 ACT FP
WINDER 30680
RANDOLPH,W. T. 03 DE5 FP
716 3RD AVE.,, WINDER 30680
RANKIN,JOSEPH L. 29 ACT D
384 PEACHTREE ST. NE, ATLANTA 30308
RANKINE,C. A. N. 29 ACT FP
1224 FERNWOOD CIR., ATLANTA 30319
RAO,P. S. 54 ACT PDC
MEDICAL COLLEGE OF GA., AUGUSTA 30902
RAO,R. N. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902
RAPER,HAL STUART 45 R
THE FOUNDATION, WARM SPRINGS 31830
RASCOE,E. MARSTON 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
RASMUSSEN,E. P. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
RASMUSSEN,WARREN A. 30 ACT PH
P.O. BOX 1219, BRUNSWICK 31520
RATCHFORD,WALTER J. 29 ACT OBG
1938 P'TREE RD,NW,408, ATLANTA 30309
RATHUR,BABER Z. 27 ACT EM
2355 BOLTON RD.,NW, ATLANTA 30318
RAUBER,ALBERT PAUL 22 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
RAUCH,SAMUEL DEAN 34 ACT I
710 BROAD ST., GAINESVILLE 30501
RAVELO,HUMBERTO C. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
RAVITA,JOHN S. 02 ACT FP
264 GREEN STREET, MONTICELLO 31064
RAVRY,MARIO J.R. 29 ACT GE
478 PEACHTREE ST.,NE, ATLANTA 30308
RAWLINGS,JOE D. 65 ACT FP
918 S. BROAD ST., THOMASVILLE 31792
RAWLINGS,WILLIAM 74 ACT FP
524 SPARTA RD., SANDERSVILLE 31082
RAWLINS,GEORGE M. 23 ACT EM
PHOEBE PUTNEY MEM. HOSP., ALBANY 31701
RAWLS,LEWIS L. 06 DE5 FP
1107 SOUTHERN TRUST BLDG., MACON 31201
RAWLS,OTIS GREY 23 ACT SU
910 N. JEFFERSON, ALBANY 31705
RAWLS,WILLIAM J. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
RAWSON,CLARENCE W.,JR. 11 ACT OR
P. O. BOX 6156, SAVANNAH 31405
RAY,DERRELL W. 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
RAY,WALKER L. 22 ACT PD
4112 E. PONCE DELEON AVE., CLARKSTON 30021
RAYBOURNE,JACK E. 06 ACT ANES
2934 VICTORIA CIR., MACON 31201
RAYEL,PETER A. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
RAYLE,ALBERT A.,JR. 29 ACT R
490 PEACHTREE ST. NE, ATLANTA 30308
RAYNOR,LUTHER K.,JR. 36 ACT OBG
507 N. HOUSTON RD., WARNER ROBINS 31093
RAZURI,RAFAEL G. 11 ACT SU
1020 DRAYTON ST., SAVANNAH 31401
RE,PETER K. 17 ACT N
50 PLAZA WAY, STE.B, MARIETTA 30060
READ,BEN S. 29 R G
390 BLACKLAND RD,NW, ATLANTA 30342
READ,JOS. C. 29 DE5 SU
3970 VERMONT RD. NE, ATLANTA 30319
READ,SILAS C.,JR. 15 ACT OPH
957 BAXTER ST., ATHENS 30601
REBUELTA,MANUEL A. 59 ACT FP
169 DECATUR ROAD, MCDONOUGH 30253
REDD,BRYAN L.,JR. 29 ACT R
401 PEACHTREE ST. NE, ATLANTA 30308
REDD,STEPHEN S. 29 ACT PD
2760 FELTON DR., EAST POINT 30344
REED,EDGAR A. 29 S I

REED,JOHN H.,JR. 34 ACT OPH
1128 VINE ST. NE, GAINESVILLE 30501
REES,BRIGITTA A. 29 ACT N
80 BUTLER ST.,SE, ATLANTA 30303
REEVE,THOMAS E.,JR. 10 ACT SU
CARROLLTON 30117
REEVES,J. LANE 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31406
REEVES,MARTIN M. 29 ACT ANES
485 N. HARBOR DR., ATLANTA 30328
REEVES,NATHAN 54 ACT I
2264 WRIGHTSBORO RD., AUGUSTA 30904
REEVES,SEAB E. A. 42 ACT ANES
219 WAVERLY DR., DUBLIN 31021
REEVES,W. HARRISON 29 ACT I
478 PEACHTREE STREET NE, ATLANTA 30308
REGALADO,JACINTO 02 A FP
P.O. BOX 578, HARDWICK 31034
REHERT,GERALD M. 29 ACT OBG
490 PEACHTREE ST, #132-B, ATLANTA 30309

REICH,GEORGE A. 29 S PH
PEACHTREE 7TH BLDG., ATLANTA 30323
REICH,ROBERT A. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
REID,JAMES W. 65 DE5
THOMASVILLE 31792
REID,RAYMOND J.,JR. 10 ACT FP
P. O. BOX 325, TALLAPOOSA 30176
REID,WM. A. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
REIFLER,R. M. 06 ACT D
729 PINE ST., MACON 31201
REILLY,ENOS J. 17 ACT OBG
513 CAMPBELL HILL, MARIETTA 30060
REISH,MARTIN L. 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
REISMAN,EDWARD D. 29 ACT SU
25 PRESCOTT ST, ATLANTA 30308
REITH,PAUL L. 45 ACT OR
P.O. BOX 421, WARM SPRINGS 31830
REITT,J. PETER 29 ACT NS
100 COLONY SQUARE, ATLANTA 30361
RELEFORD,CHARLES C. 59 ACT
218 W. BROAD ST., GRIFFIN 30223
REMY,HENRY 22 ACT PD
798 RAYS RD., STONE MOUNTAIN 30083
RENTZ,TURNER W. 58 ACT FP
COLQUITT 31737
RETTERBUSH,W. C. 56 ACT SU
BOX 2313, VALDOSTA 31603
REVELL,WALTER J. 39 ACT
P.O. BOX 5, LOUISVILLE 30434
REY,CHARLES J.,JR. 17 ACT SU
4399 AUSTELL RD., AUSTELL 30001
REY,ROBERTO 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
REYNAUD,L. F. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310
REYNAUD,VIRGINIA G. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310
REYNOLDS,G. THOMAS 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
REYNOLDS,J. S. 29 ACT FP
553 MOBILE AVE. SW, ATLANTA 30315
REYNOLDS,JAMES WILEY 26 ACT FP
P.O. BOX 549, ASHBURN 31714
REYNOLDS,JOHN D. III 54 ACT NS
1521 POPE AVE., AUGUSTA 30904
REYNOLDS,KENNETH H. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
REYNOLDS,MILTON B.,JR. 21 ACT FP
DONALSONVILLE CLINIC, DONALSONVILLE 31745
RHAME,DONALD W. 06 ACT SU
700 SPRING ST., MACON 31201
RHAME,MARLAN L. VAN 22 ACT P
755 COLUMBIA DR., DECATUR 30030
RHANGOS,WILLIAM C. 11 ACT OR
210 E. HALL ST., SAVANNAH 31401
RHEA,JAMES W. 47 A PD
ARAMCO BOX 2438, DHAHRAN SAUDI ARABIA
RHENEY,THEODORE B. 22 ACT FP
2701 N. DECATUR RD., DECATUR 30030
RHODE,CHARLES MARTIN 54 ACT SU
VA HOSPITAL, AUGUSTA 30904
RHODES,E. LEEON 27 ACT SU
HARBIN CLINIC, ROME 30161
RHODES,WM. H.,JR. 49 ACT FP
100 SCOTT ST., UNION POINT 30669
RHYNE,WALTER P. 23 DE5 OALR
P. O. BOX 806, ALBANY 31702
RICE,GUY V. 03 R PH
3116 RANDOLPH RD. NE, ATLANTA 30345
RICE,JOSEPH F. 45 ACT I
WARM SPRINGS HOSPITAL, WARM SPRINGS 31830
RICE,KEITH C. 29 DE5 SU
RT. 1, CLAYTON 30525
RICE,M. HOBSON 22 ACT OPH
542 CHURCH STREET, DECATUR 30030
RICE,SAMUEL T. 47 ACT U
1430 THIRD AVE., COLUMBUS 31901
RICHARDS,CHARLES K. 27 ACT R
FLOYD HOSP., ROME 30161
RICHARDSON,A. C.,JR. 29 ACT OBG
710 PEACHTREE ST. NE, ATLANTA 30308
RICHARDSON,C. H.,JR. 06 ACT SU
724 HEMLOCK ST., MACON 31201
RICHARDSON,CHARLES R. 08 ACT OBG
P. O. BOX 1066, STATESBORO 30458
RICHARDSON,HOWARD D. 29 ACT NS
340 BOULEVARD NE, ATLANTA 30312
RICHARDSON,R. C. 23 ACT OALR
400 4TH AVE., ALBANY 31705
RICHARDSON,RUSSELL E. 34 ACT FP
HALL CO. HOSP., GAINESVILLE 30501
RICHARDSON,STERLING H. 29 ACT SU
490 P'TREE ST,NE,STE. 356-B, ATLANTA 30308
RICHMAN,GARY O. 29 ACT OPH
3316 PIEDMONT RD. NE, ATLANTA 30305
RICHMOND,LEA 29 ACT SU
6500 VERNON WOODS DR., ATLANTA 30328
RICHTER,WILLIAM H. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
RICKS,HENRY C.,JR. 29 ACT P
415 E. PACES FERRY RD. NE, ATLANTA 30305
RICKS,ROBERT L. 29 ACT OBG
565 FAIR ST. SW, ATLANTA 30314
RIDLEY,C. L.,JR. 06 ACT SU
380 HOSPITAL DR., MACON 31201
RIDLEY,HARRY W. 29 DE5 FP
SEA ISLAND 31561
RIDLEY,JOHN H. 29 ACT G
35 COLLIER RD. NW, ATLANTA 30309
RIESER,CHARLES 29 DE5 U
3777 PACES FERRY RD. NW, ATLANTA 30327
RIESER,JOHN C. 29 ACT OPH
1365 CLIFTON RD. NE, ATLANTA 30322
RIGAS,LAMBROS C. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161
RIGBY, DAVID B. 76 ACT R
P.O. BOX 1285, DALTON 30720
RIGBY,JUDY A. 76 ACT PD
MEDICAL ARTS BLDG.,STE.E, DALTON 30720
RILEY,WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236
RINKER,J. ROBERT 54 ACT U
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
RIST,KARL H. 29 S R
2440 EDGEWATER DR,SW, ATLANTA 30311
RITCHEY,STERLING J. 29 ACT OR
EMORY UNIV. CLINIC, ATLANTA 30322
RIVERS,SHIRLEY L. 29 A I
1925 MONROE DR. NE, ATLANTA 30324
RIVERS,W. P.,JR. 47 ACT PD
2520 WYNNTON RD., COLUMBUS 31906
RIVKIN,LAWRENCE M. 29 ACT TS
1220 PACES FOREST DR. NW, ATL 30327
RIZO,MIGUEL A. 76 ACT P
2204 DRUID LANE, DALTON 30720
ROACH,GEORGE S.,JR. 29 ACT ALR
144 PONCE DE LEON AVE. N.E., ATLANTA 30308
ROBBINS,FRANK T. 62 ACT FP
513 OGLETHORPE BLVD., HINESVILLE 31313
ROBERSON,PHIL E. 23 ACT OBG
P. O. BOX 343, ALBANY 31702
ROBERTS,B. J. 33 A I
MED. DIR., DIST. 22, TOCCOA 30577
ROBERTS,DAVID B. 47 ACT OBG
2400 13TH ST., COLUMBUS 31906
ROBERTS,DON R.,JR. 30 ACT OR
3204 SHRINE RD., BRUNSWICK 31520
ROBERTS,LUTHER J. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
ROBERTS,RALPH D. 05 ACT FP
FITZGERALD 31750
ROBERTS,SAVA M. 61 ACT R
P.O. BOX 2938, AUGUSTA 30904
ROBERTS,STEWART R.,JR. 17 ACT R
80 BUTLER ST. SE, ATLANTA 30303
ROBERTSON,ALEX F. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902

ROBERTSON,MASON G. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406
ROBINSON,A. CLARK 10 ACT FP
P. O. BOX 1116, DOUGLASVILLE 30134
ROBINSON,ALBERT H. 29 A PH
3060 PHARR COURT NW, ATLANTA 30305
ROBINSON,DAVID 11 A R
P.O. BOX 876, SAVANNAH BEACH 31328
ROBINSON,J. C. 10 ACT R
TANNER MEM. HOSP., CARROLLTON 30117
ROBINSON,J.L. 45 ACT
P.O. BOX 481, CARROLLTON 30117
ROBINSON,JOE S. 06 ACT SU
655 FIRST ST., MACON 31201
ROBINSON,JOHN H.,III 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
ROBINSON,PAUL H. 29 ACT C
1365 CLIFTON RD. NE, ATLANTA 30322
ROBINSON,RALPH L. 29 ACT PD
3158 MAPLE DR. NE, ATLANTA 30305
ROBINSON,ROBERT S. 08 ACT FP
P. O. BOX 45, METTER 30439
ROBINSON,THOMAS F. 54 ACT EM
UNIVERSITY HOSPITAL, AUGUSTA 30902
ROBITSCHER,JONAS 29 ACT P
EMORY UNIV. LAW SCHOOL, ATLANTA 30322
ROCHE,WM. PATRICK,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
RODDENBERRY,HARVEY B. 06 ACT OBG
380 HOSPITAL DR. SUITE 100, MACON 31201
RODDENBERY,S. A. 47 ACT SU
213 DOCTORS BLDG., COLUMBUS 31901
RODRIGUEZ,A. P. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
RODRIGUEZ,FERNANDO 29 S I
P. O. BOX 33115, DECATUR 30033
RODRIGUEZ,HUMBERTO 56 ACT SU
P. O. BOX 2274, VALDOSTA 31601
RODRIQUEZ,J. I. 29 ACT I
3307 PRINCE GEORGE ST., EAST POINT 30344
RODZEWICA,PAUL J. 29 ACT I
400 COLONY SQUARE #1605, ATLANTA 30361
ROGERS,A. A. 37 DE5 FP
COMMERCE 30529
ROGERS,A.A.,JR. 37 ACT FP
COMMERCE 30529
ROGERS,CHARLES G. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
ROGERS,EDWARD A.,JR. 19 ACT OBG
700 S. MAIN, MOULTRIE 31768
ROGERS,HARRISON L.,JR. 29 ACT SU
1938 PEACHTREE RD NW #601, ATLANTA 30309
ROGERS,J. HARRY 29 DE5 SU
490 PEACHTREE ST. NE, ATLANTA 30308
ROGERS,J. V.,JR. 22 ACT R
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
ROGERS,JAMES W. 06 ACT EM
3055 GENERAL LEE RD., MACON 31204
ROGERS,T. E.,JR. 06 ACT OBG
380 HOSPITAL DR., MACON 31201
ROLLINGS,HARRY E. 11 ACT I
100 E. PARK AVE., SAVANNAH 31401
ROMINE,BENJAMIN W. 65 ACT FP
P.O. BOX 232, QUITMAN 31643
ROMITAM,EMIL 36 ACT OTO
1120 MORNINGSIDE DR, PERRY 31036
ROOF,JACK B.,JR. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
ROOKER,DONALD W. 29 ACT ALR
960 JOHNSON FERRY RD.,NE, ATLANTA 30342
ROONEY,DONALD R. 17 ACT R
70 TOWER RD. NW, MARIETTA 30060
ROPER,C. J. 14 DE5 SU
JASPER 30143
ROPER,E. A. 14 ACT FP
JASPER 30143
ROPER,RONALD P. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROQUE,R. T. 11 ACT FP
SPRINGFIELD MED. PROF., SPRINGFIELD 31329

ROSE,A. MCKOY,JR 17 ACT SU
732 CHEROKEE ST., MARIETTA 30061
ROSE,CORDT E. 15 ACT ANES
110 CHINQUAPIN WAY, ATHENS 30601
ROSE,DANIEL W. 11 ACT OTO
17 MEDICAL ARTS CENTER, SAVANNAH 31405
ROSE,FRED D. 29 ACT I
272 BOULEVARD,NE, ATLANTA 30312
ROSEN,ARNOLD J. 29 ACT SU
1916 PATTERSON ST.,300, NASHVILLE,TN. 37203
ROSEN,BARRETT F. 76 DE2 OR
1916 PATTERSON ST #300, NASHVILLE, TN 37203
ROSEN,E. F. 11 ACT OALR
5 E. GORDON STREET, SAVANNAH 31401
ROSEN,RONALD 17 ACT U

ROSEN,SAMUEL F. 11 DE5 D
P.O. BOX 960, SAVANNAH BCH. 31328
ROSENBAUM,BARRY J. 29 ACT NE
1365 CLIFTON RD NE, ATLANTA 30322
ROSENBERG,RAYMOND 22 ACT PD
11 LAVISTA PERIMETER OFC. PK, TUCKER 30084
ROSENGART,CARL L. 11 ACT N
P.O. BOX 6683, SAVANNAH 31405
ROSS,THOMAS L. 06 ACT I
944 NOTTINGHAM DR., MACON 31201
ROSSI,ALBERTO E. 29 ACT OBG
1100 CLEVELAND AVE.,201, EAST POINT 30344
ROSSITER,FRANCIS P.,JR. 11 ACT AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
ROTHENBERG,MARVIN B. 29 ACT OR
6500 VERNON WOODS DR. NE, ATL. 30328
ROTTERSMAN,WILLIAM 29 ACT P
3280 HOWELL MILL RD. N. W., ATLANTA 30327
ROUGHTON,RALPH E.,JR. 29 ACT P
1175 PEACHTREE ST. NE, ATLANTA 30309
ROULE,J. VICTOR 54 DE1 OALR
2251 CUMMING RD., AUGUSTA 30904
ROUNTREE,CLYDE B. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
ROUTLEDGE,JAMES A. 27 ACT SU
310 W. SIXTH ST., ROME 30161
ROUTON,JAMES L. 29 ACT ANES
705 JUNIPER ST. NE, ATLANTA 30308
ROWE,THOMAS S. 29 ACT OPH
490 PEACHTREE ST.,NE, ATLANTA 30308
ROWELL,ROGER R. 22 ACT OPH
542 CHURCH ST., DECATUR 30030
ROWLAND, JAMES M., III 06 ACT I
811 ORANGE TERR., MACON 31201
ROWLAND,DAVID M. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
ROWLAND,J. ROY,JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
ROWLEY,CHARLES M. 06 ACT N
740 HEMLOCK ST., MACON 31201
ROZIER,D. H. 06 ACT ANES
5151 ZEBULON RD., MACON 31204
RUBENSTEIN,ARNOLD B. 29 ACT U
2788 BAYARD ST., EAST POINT 30344
RUBIN,JOSEPH W. 54 ACT TS
MCG, AUGUSTA 30902
RUCKER,J. T.,JR. 54 ACT ANES
812 13TH ST., AUGUSTA 30901
RUDDER,FRED F. 29 DE5 SU

RUDER,ERNST M. 29 ACT R
12411 KING'S LAKE DR., RESTON,VA 22091
RUDOLPH,STEPHEN J.,JR. 18 ACT IND
702 N. GASKIN AVE., DOUGLAS 31533
RUMBLE,CHARLES T. 06 ACT PD
RT. 3, BOX 43, FORSYTH 31029
RUNDLE,T. J. 61 ACT OPH
P.O. BOX 1026, AMERICUS 31709
RUSCA,JOHN A. 29 ACT PL
5675 PEACHTREE DNWDY RD, ATLANTA 30328
RUSHIN,C. E. 29 DE5 SU
478 PEACHTREE STREET NE, ATLANTA 30308
RUSSELL,ALEX P. 11 ACT PATH
MEMORIAL MEDICAL HOSP., SAV. 31405

RUSSELL,DAVID A. 29 ACT FP
340 BOULEVARD NE, ATLANTA 30312
RUSSELL,E. K. 29 ACT I
600 W. PEACHTREE ST.,NE, ATLANTA 30308
RUSSELL,FREDERICK L. 76 A FP
P. O. BOX 564, DALTON 30720
RUSSELL,R. JAMES 29 ACT PL
3250 HOWELL MILL RD. NW, ATLANTA 30327
RUSSELL,ROGER K. 18 ACT FP
P.O. BOX 779, PEARSON 31642
RUTLEDGE,BEN A. 29 DE1 OR
2348 ECHO CLIFF CT. NE, ATLANTA 30345

S

SAFER,IRWIN H. 11 ACT P
515 E. 63 ST., SAVANNAH 31405
SAFFAN,B. D. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308
SAKER,A. F. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30341
SALAM,ATEF A. 29 ACT SU
69 BUTLER ST. SE, ATLANTA 30303
SALE,WALTER T. 29 ACT R
35 COLLIER RD. NW, ATLANTA 30309
SALEHBHAI, MANSOOR, 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
SALTER,PAUL P. III 29 A SU
3131 LAVENTURE DR., CHAMBLEE 30341
SALTER,W. L. 11 DE1 FP
8915-A OLD MONTGOMERY RD., SAV. 31406
SAMARA,DAVID J. 61 ACT U
1102 E. LAMAR ST., AMERICUS 31709
SAMMONS,EDWARD E. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322
SAMS,FERROL A.,JR. 16 ACT FP
FAYETTEVILLE 30214
SAMS,FRANK H.,JR. 61 ACT FP
BOX 536, REYNOLDS 31076
SAMS,HELEN F. 16 ACT
FAYETTEVILLE 30214
SAMS,WILLIAM C.,JR. 05 ACT FP
OCILLA 31774
SAMSON,ANTONIO L. 01 ACT FP
306 W. MANN ST., GLENNVILLE 30427
SANCHEZ,ELIO S. 27 ACT I
BATTEY STATE HOSP., ROME 30161
SANCHEZ,FRANCISCO R. 70 ACT FP
1800 LAFAYETTE RD., FT. OGLETHORPE 30742
SANCHEZ,FRED H. 29 A SU
1422 OAK CT NE, ATLANTA 30319
SANDBERG,JOHN 17 ACT
KING-WILLIAMS BLDG., SMYRNA 30080
SANDERS,BEVERLY B.,JR. 06 ACT D
700 SPRING ST., MACON 31201
SANDERS,C. VERNON 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
SANDERS,CONRAD W.,JR. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902
SANDERS,DRAYTON M.,II 76 ACT I
MEMORIAL DR., DALTON 30720
SANDERS,F. HUNT 36 ACT ANES
ROUTE 4, COCHRAN 31014
SANDERS,FLOYD R.,JR 22 ACT FP
603 CHURCH ST., DECATUR 30030
SANDERS,GERALD E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
SANDERS,J. LARRY 76 ACT OBG
1217 MEMORIAL DR., DALTON 30720
SANDERS,RUTH J. 54 ACT R
1021 15TH ST., AUGUSTA 30904
SANDERS,STEVEN L. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
SANDISON,J. CALVIN 29 DE5 OR

SANFORD,SHELTON P. 15 A I

SANKARAN,K. N. V. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709
SANTIAGO, MARCELO R. 08 ACT SU
P.O. BOX 800 , CLAXTON 30417
SANTOS,TEODORO DE LOS 23 ACT PATH
P.O. BOX 1828, ALBANY 31702
SAPP,CLARENCE J. 27 ACT SU
200 E. 3RD ST., ROME 30161
SAPP,GERALD L. 66 ACT OR
P.O. BOX 1368, TIFTON 31794
SAPP,PHILIP B. 76 ACT EM
HAMILTON MEM HOSP,PO BOX 1168, DALTON 30720
SAPPINGTON,T. A. 69 ACT FP
612 W. GORDON ST., THOMASTON 30286
SARGENT,CARLTON W. 29 A PH
618 PONCE DE LEON AVE. NE, ATLANTA 30308
SATCHER,MILTON B.,JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344
SATHE,ANAND J. 42 ACT OBG
107 VERNON ST., DUBLIN 31021
SAUNDERS,A. F. 56 DE5 OBG
P. O. BOX 2035, VALDOSTA 31603
SAUNDERS,ELWYN A. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902
SAVAGE,C. P. 61 DE5 FP
MONTEZUMA 31063
SAWYER,HORACE K.,JR. 22 ACT FP
2054 LAWRENCEVILLE HWY., DECATUR 30033
SAX,CHARLES E. 11 ACT OBG
120 E. 34TH STREET, SAVANNAH 31401
SAYE,WILLIAM B. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
SCARBROUGH,ROGER W.,JR. 11 ACT OBG
11706 MERCY BLVD., SAVANNAH 31406
SCARDINO,PETER L. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403
SCHAEFER,W. B. 60 DE1 SU
19525 SW 248TH ST., HOMESTEAD,FLA. 33030
SCHARF,FORREST L. 36 ACT PATH
BOX 882, LAKELAND,FL. 33802
SCHARFF,LOUIS,III 54 ACT PD
GRACEWOOD HOSPITAL, GRACEWOOD 30812
SCHATTEN,WM. E. 29 ACT PL
3280 HOWELL MILL RD NW #11, ATLANTA 30327
SCHEIDT,KENNETH A. 29 ACT
35 LINDEN AVE,NE, ATLANTA 30308
SCHELLACK,J. K. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
SCHERMERHORN,THOMAS J. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
SCHIENEMAN,BRUCE O. 06 ACT I
MEDICAL CENTER OF CENTRAL GA., MACON 31201
SCHILLER,HERBERT M. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31901
SCHILLING,ROBINSON W. JR 54 ACT OTO
2283 WRIGHTSBORO ROAD, AUGUSTA 30904
SCHLANT,ROBERT C. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
SCHLEY,FRANCIS B.,JR. 47 ACT PD
303 11TH STREET, COLUMBUS 31901
SCHLEY,PHILIP T. 47 ACT U
717-20TH ST., COLUMBUS 31404
SCHLEY,RICHARD L.,JR. 11 ACT PD
5509 PAULSEN ST., SAVANNAH 31405
SCHLOSSBERG,MICHAEL 29 ACT OBG
2788 BAYARD ST., EAST POINT 30344
SCHLOTTMAN,GEORGE C. 06 ACT U
718 FIRST ST., MACON 31201
SCHMIDT,DON 27 ACT FP
P. O. BOX 368, CEDARTOWN 30125
SCHMIDT,F. K. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060
SCHMIDT,RICHARD E. 04 ACT EM
P.O. BOX 1008, CARTERSVILLE 30120
SCHMITT,ELBERT W.,JR. 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
SCHNEIDER,M.M. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHNEIDER,WILBUR D. 07 ACT FP
BOX 407, ELLIJAY 30540
SCHNEIDERMAN,STEVEN M. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033

SCHNICK,JOHN C. 47 ACT FP
MEDICAL CENTER HOSP., COLUMBUS 31902
SCHNUCK,LLOYD B. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHOENBUCHER,ALBERT K. 29 A OBG
47 TRINITY AVE. SW, ATLANTA 30334
SCHOFFSTALL,ROBERT O.. 06 ACT SU
P. O. BOX 6000, MACON 31208
SCHREEDER,JOHN M. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
SCHRODER,J. SPALDING 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
SCHUESSLER,CARL C. 06 ACT OBG
380 HOSPITAL DR., MACON 31201
SCHUESSLER,GEORGE 47 ACT FP
302 DOCTORS BLDG., COLUMBUS 31901
SCHULZE,RICHARD R. 11 ACT OPH
728 E. 67TH ST., SAVANNAH 31405
SCHWARTZ,JAMES F. 29 ACT PD
69 BUTLER ST. SE, ATLANTA 30303
SCHWARTZ,LARRY A. 06 ACT PD
376 ROGERS AVE., MACON 31204
SCHWARTZ,ROBERT I. 06 ACT PD
376 ROGERS AVE., MACON 31204
SCHWARTZ,SANFORD H. 29 ACT I
4536 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
SCHWARZMANN,STEPHEN W. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
SCOGGIN,W. A. 54 ACT OBG
TALMADGE MEM. HOSP., AUGUSTA 30902
SCOGGINS,HENRY D. 54 ACT OBG
1501 ANTHONY RD., AUGUSTA 30904
SCOGGINS,P. T. 37 DE5 FP
COMMERCE 30529
SCOTT,CHARLES JR. 29 ACT U
340 BLVD.,NE, ATLANTA 30303
SCOTT,LEGH R. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
SCOTT,THOMAS P.,JR. 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344
SCOTT,WILBUR M. 02 ACT SU
230 JEFFERSON ST., MILLEDGEVILLE 31061
SCOTT,WILLIAM M.W. 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
SEAGO,RICHARD W. 10 ACT SU
405 ALABAMA AVE., BREMEN 30110
SEALEY,ROMERO M. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SEALY,HUGH K. 06 ACT I
765 SPRING ST., MACON 31201
SEARCY,ASHBURN P. 54 ACT ANES
P. O. BOX 2820, AUGUSTA 30904
SEARS,ROBERT A. 06 ACT NS
1175 PEACHTREE ST. NE, ATLANTA 30361
SEAVEY,PAUL W. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
SEAY,E. FAXTON 36 ACT
BOX 208, FT. VALLEY 31030
SEESE,PERRY G. 22 ACT P
2151 PEACHFORD RD., CHAMBLEE 30341
SELF,STANLEY J. 27 ACT D
302 W. 6TH ST., ROME 30161
SELL,M. B.,JR. 54 ACT P
MEDICAL COLLEGE OF GA., AUGUSTA 30902
SELLERS,SIDNEY L. 76 ACT G
P. O. BOX 1138, DALTON 30720
SELLERS,T. F. 29 DE5
STATE DEPT. OF PUB. HEALTH, ATLANTA 30334
SELMONOSKY,CARLOS A. 29 ACT TS
1678 MULKEY RD., AUSTELL 30001
SELVEY,HENRY A. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
SENEVIRATNE,D. G. 47 ACT EM
710 CENTER ST., COLUMBUS 31902
SENG,BARRY S. 36 ACT FP
100 PICKETT CT., WARNER ROBINS 31093
SENNETT,CHARLIE O.,JR. 27 ACT PATH
FLOYD HOSP., ROME 30161
SERBES,YILMAZ A. 29 ACT OR
5583 GORDON RD., MABLETON 30059
SERGENT,PAUL M. 37 ACT FP
335 SOUTH BROAD ST, COMMERCE 30529
SERRATO,J. C.,JR. 47 ACT OR
DOCTORS BUILDING, COLUMBUS 31901
SESSIONS,GEORGE P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
SESSIONS,HOWARD K. 29 A PH
P. O. BOX 781, SUMNER 31789
SESSIONS,ROBERT T. 17 ACT SU
811 CHURCH ST., MARIETTA 30062
SETZER,EDWARD H. 60 ACT I
800 E. DOYLE ST., TOCCOA 30577
SEVERS,RONALD G. 36 ACT SU
DOCTORS CLINIC, WARNER ROBINS 31093
SEWELL,JESSE Q. 06 ACT FP
784 SPRING ST., MACON 31201
SEYMOUR,GLENN E. 23 ACT SU
412 FOURTH AVE., ALBANY 31705
SHACKELFORD,HUGH W. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SHACKLETT,ROBERT S. 69 ACT PATH
UPSON CO HOSP, BOX 1059, THOMASTON 30286
SHAH,NARENDRA K. 68 ACT R
CALLAWAY CANCER CLINIC, LAGRANGE 30240
SHAMA,ZOUTHEIR A. 29 ACT SU
2931 APPLING DR., CHAMBLEE 30341
SHANKS,JAMES Z. 29 ACT I
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
SHANTHA,TOTADA R. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
SHAPIRO,STANLEY T. 17 ACT OTO
2550 WINDY HILL RD.,#106, MARIETTA 30062
SHARMA,KAILASH B. 54 ACT PATH
UNIV. HOSP., AUGUSTA 30902
SHARPLEY,JOHN G. 11 ACT SU
1903 ABERCORN ST., SAVANNAH 31401
SHAVIN,JOEL S. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084
SHEA,P. C.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
SHEAHAN,ROBERT C. 29 A ACM
1800 PEACHTREE ST. NE, ATLANTA 30309
SHEALY,FRED G. 11 A SU
MEMORIAL MEDICAL CENTER, SAVANNAH 31405
SHEALY,L. M. 65 ACT FP
P. O. BOX 631, QUITMAN 31643
SHEFFIELD,CHARLES RAY 53 ACT FP
JOHNSON STREET, DAWSON 31742
SHEFFIELD,PHILIP 15 ACT
1010 PRINCE AVE., ATHENS 30601
SHEHEE,WALTER H. 29 ACT P
1338 CLEVELAND AVE., EAST POINT 30344
SHEILS,ANDREW T.,JR. 11 ACT OR
#7 ST. JOSEPHS PROF. PLAZA, SAVANNAH 31406
SHELOR,WILLIAM C.,JR. 06 ACT U
718 FIRST ST., MACON 31201
SHELTON,THOMAS G. 47 ACT I
1952 NORTH AVE., COLUMBUS 31901
SHEPARD,DUNCAN 29 ACT SU
3312 PIEDMONT RD. NE, ATLANTA 30305
SHEPARD,KIRK 65 DE1 SU
204 JURMIS ST., THOMASVILLE 31792
SHEPEARD,WALTER L. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902
SHEPHERD,EDWIN C. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
SHEPHERD,MASON H. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902
SHERMAN,ELOISE B. 11 ACT PATH
P.O. BOX 6542, STA. C, SAVANNAH 31405
SHERMAN,HARRY C. 54 ACT SU
3010 SUSSEX DR., AUGUSTA 30904
SHERMAN,HENRY T. 56 R I
P.O. BOX 1409, VALDOSTA 31601
SHERRER,WEBSTER A. 17 ACT PATH
KENNESTONE HOSPITAL, MARIETTA 30061
SHESSEL,HERBERT L. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
SHIELDS,JOSEPH D.,III 06 ACT I
618 ORANGE ST., MACON 31201

SHIFLET,ROBERT E. 15 ACT U
1010 PRINCE AVE., ATHENS 30601
SHIH,CHEN-WEN 62 ACT OBG
P.O. BOX 406, HINESVILLE 31313
SHINALL,ROBERT P. 29 DE1 FP
927 ARTWOOD RD. NE, ATLANTA 30307
SHIRLEY,JACOB L.,JR. 23 ACT FP
411 S. MADISON ST., ALBANY 31701
SHIRLEY,WM. C. 06 ACT OBG
380 HOSP. DR., MACON 31201
SHIVER,CHARLES B. 54 ACT
806-13TH ST., AUGUSTA 30901
SHIVERS,OLIN C. 29 ACT PD
47 PEACHTREE PKWY., NE, ATLANTA 30309
SHMERLING,SANFORD A. 29 ACT I
3316 PIEDMONT RD. NE, ATLANTA 30305
SHOEMAKER,KENNETH E. 22 ACT P
500 WINN WAY, DECATUR 30030
SHORT,DWIGHT H.,II 54 A SU
MED. COLL OF GA., AUGUSTA 30902
SHORTER,HENRY F.,JR. 29 ACT FP
960 HUNTER ST. SW, ATLANTA 30314
SHOTTS,RON F. 22 ACT OTO
1989 N. WILLIAMSBURG DR., DECATUR 30033
SHUFORD,WADE H. 29 A R
80 BUTLER ST. SE, ATLANTA 30303
SHULER,ROBERT K. 29 ACT PD
3158 MAPLE DR.,NE, ATLANTA 30305
SHULMAN,MICHAEL G. 29 ACT I
3200 HOWELL MILL RD, NW, ATLANTA 30327
SHUMAN,VILDA 72 ACT PD
WAYCROSS 31501
SIEGAL,JEROME H. 29 DE2 I
215 E.68TH ST.,APT 10-M, NEW YORK,NY 10021
SIEVERT,ALAN J. 29 ACT PD
1100 CLEVELAND AVE., EAST POINT 30344
SIGAL,HOWARD MARVIN 17 ACT PD
3001 S. COBB DR., SMYRNA 30080
SIGMAN,CHENEY C. 29 ACT AL
3393 PEACHTREE RD. NE, ATLANTA 30326
SIGMAN,HOLLIS D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
SIKES,ZACHARIAH S.,JR. 06 ACT P
803 SPRING ST., MACON 31201
SILAN,J. RUBEN D. 62 ACT SU
P.O. BOX 844, HINESVILLE 31313
SILLER,EVERARD J. 29 ACT N
MONASTERY OF THE HOLY SPIRIT, CONYER 30207
SILVER,WILLIAM E. 22 ACT OTO
1770 OLD SPRNGHSE LN NE, CHAMBLEE 30341
SILVERMAN,BARRY D. 29 A C
1000 JOHNSON FRY. RD. NE, ATLANTA 30342
SILVERMAN,MARK E. 29 A I
1968 PEACHTREE RD.,NW, ATLANTA 30309
SILVERMAN,STUART H. 29 ACT OPH
5040 SNAPFINGER WOOD RD., DECATUR 30035
SILVERSTEIN,CHARLES M. 29 ACT R

SIMMONS,JOHN W.,III 22 ACT PD
4112 E.PONCE DE LEON AVE., CLARKSTON 30021
SIMMONS,M. FREEMAN 22 ACT FP
301 WOODVIEW DR., DECATUR 30030
SIMMONS,MACK 30 ACT SU
338 MAJOR WRIGHT, SIMONS ISLAND 31522
SIMMONS,ROBERT W. 76 ACT FP
1203 MEMORIAL DR., DALTON 30720
SIMMONS,WILLIAM C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
SIMONE,GREGORY L. 29 A
80 BUTLER ST. SE, ATLANTA 30303
SIMPSON,HARVEY L. 61 ACT SU
1102 LAMAR ST., AMERICUS 31709
SIMPSON,MARSHALL A. 47 ACT P
BRADLEY CTR., COLUMBUS 31901
SIMPSON,WALTER W. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31901
SIMS,A. R. 53 ACT
RICHLAND 31825
SIMS,FAYETTE A.,JR. 13 ACT
LAWRENCEVILLE 30245
SIMS,FRED E. 23 ACT ANES
107 S. JEFFERSON ST., ALBANY 31702
SIMS,J.P. 70 ACT FP
1 THOMAS RD., FT. OGLETHORPE 30742
SIMS,JAMES A. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
SIMS,S.E. 29 ACT SU
100 EDGEWOOD AVE, SE, ATLANTA 30303
SIMS,S.E. 29 ACT SU
100 EDGEWOOD AVE SE #1605, ATLANTA 30303
SIMS,WILLIAM G. 47 ACT PL
SUITE 212, DOCTORS BLDG, COLUMBUS 31901
SINGER,ARTHUR G. 60 ACT R
TOCCOA 30577
SINGH,MANJIT 54 ACT GE
VA HOSPITAL, AUGUSTA 30904
SINGLETARY,ELIZABETH A. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
SINGLETON,C. K. 65 ACT
FIRST AVENUE SE, CAIRO 31728
SISSON,WILLIAM H. 11 ACT P
BOX 6688 STA C, SAVANNAH 31405
SIZEMORE,JULIAN J.,JR. 47 ACT PD
808 21ST ST., COLUMBUS 31904
SKANDALAKIS,JOHN E. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
SKARDASIS,GEORGE M. 29 ACT VS
25 PRESCOTT ST. NE, ATLANTA 30308
SKEEL,DAVID A. 54 ACT U
MCG., AUGUSTA 30902
SKELTON,C. B. 03 ACT FP
WINDER 30680
SKELTON,MARVIN E. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405
SKELTON,W. DOUGLAS 29 ACT P
47 TRINITY AVE. SW, ATLANTA 30334
SKINNER,JAMES M. 59 ACT OBG
610 SOUTH EIGHTH STREET, GRIFFIN 30223
SKINNER,JOHN J.,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
SKIPWORTH,GEORGE B. 47 ACT D

SKOBBA,JOSEPH S. 29 A P
2386 DELLWOOD DR. NW, ATLANTA 30305
SKORAPA,MARY Z. 29 ACT PM
VA HOSPITAL, TOGAS,MAINE 04330
SLADE,JOHN DE R. 29 ACT I
768 JUNIPER ST. NE, ATLANTA 30308
SLATE,ROBERT W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
SLOAN,HERBERT P. 76 ACT PATH
HAMILTON MEM HOSP,PO BOX 1168, DALTON 30720
SLOAN,W. P. 29 DE5 I
340 BLVD. NE, ATLANTA 30312
SLOAN,W. P.,JR. 29 ACT I
340 BLVD. N. E., ATLANTA 30312
SLUTSKY,MORTON 29 ACT PL
275 CARPENTER DR. NW, ATLANTA 30328
SMAHA,T. G. 59 ACT G
600 SOUTH 8TH STREET, GRIFFIN 30223
SMILEY,DAVID T. 29 ACT ALR
3316 PIEDMONT RD. NE, ATLANTA 30305
SMILEY,F. JONES 70 ACT OBG
1816 LAFAYETTE RD., FT. OGLETHORPE 30742
SMILEY,RUSSELL B.,JR. 29 ACT C
JOAN GLANCY MEMORIAL HOSPITAL, DULUTH 30136
SMISSON,HUGH F. 06 ACT NS
740 HEMLOCK ST., MACON 31201
SMITH,AMOS A. 54 ACT ANES
P.O.BOX 2765, AUGUSTA 30904
SMITH,ARTHUR A. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
SMITH,C. C. 54 ACT D
1349 DRUID PARK AVENUE, AUGUSTA 30904
SMITH,C. MORGAN,JR. 05 ACT FP
MEDICAL ARTS BLDG., FITZGERALD 31750
SMITH,CARL A. 11 ACT ANES
35 LINDEN AVE., ATLANTA 30308
SMITH,CARTER 29 DE5 I
35 COLLIER RD. NW, ATLANTA 30309

SMITH,CARTER,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
SMITH,CHARLES M. 27 ACT FP
ROCKMART 30153
SMITH,CHAS. W. 29 ACT OBG
57 SIXTH ST. NE, ATLANTA 30308
SMITH,DARIUS A. 17 ACT FP
MEDICAL BLDG., DALLAS 30132
SMITH,DENNIS B. 54 ACT N
VA HOSPITAL, AUGUSTA 30904
SMITH,DON T. 66 ACT FP
1824 N. LEE ST., TIFTON 31794
SMITH,DOUGLAS 22 ACT OR
1405 CHURCH ST., DECATUR 30030
SMITH,DOUGLAS L. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30904
SMITH,E. G.,JR. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
SMITH,EDWARD H.,JR. 54 ACT D
1021 15TH ST., AUGUSTA 30901
SMITH,F. A.,JR. 64 ACT FP
MCRAE 31055
SMITH,FRANK Q. 56 ACT OBG
P. O. BOX 2748, VALDOSTA 31601
SMITH,FRED C. 56 ACT SU
DOCTORS BLDG., VALDOSTA 31603
SMITH,GARY L. 27 ACT FP
TRION 30753
SMITH,GEORGE BERTLING 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901
SMITH,H. M. 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405
SMITH,H. W. 25 ACT OB
SWAINSBORO 30401
SMITH,HENRY BRIGGS 56 ACT ALR
DOCTORS BLDG., VALDOSTA 31603
SMITH,HERBERT D. 08 ACT P
127 N. MAIN ST., STATESBORO 30458
SMITH,HILTON E. 47 ACT FP
CROSS COUNTRY PL. OFC.PK., COLUMBUS 31907
SMITH,J. DORSEY 08 ACT FP
MEDICAL ASSOC. OF METTER., METTER 30439
SMITH,J. GRAHAM 54 ACT D
MED. COLLEGE OF GA., AUGUSTA 30902
SMITH,JAMES D. 11 I&R OBG
BO 6688 STA C, SAVANNAH 31405
SMITH,JAMES E. 42 ACT SU
508 ACADEMY AVE., DUBLIN 31021
SMITH,JAMES H. 27 ACT I
7 PROFESSIONAL COURT, ROME 30161
SMITH,JAMES W. 45 ACT FP
MANCHESTER 31816
SMITH,JOEL P.,JR. 29 ACT OALR
573 W. PEACHTREE ST. NE, ATLANTA 30308
SMITH,JOHN M.,JR. 30 ACT I
P. O. BOX 1059, ST. SIMONS IS. 31522
SMITH,LEO 72 ACT OALR
BOX 778, WAYCROSS 31501
SMITH,LUCIUS S. 27 ACT R
FLOYD HOSPITAL, ROME 30162
SMITH,LUTHER J.,II 47 ACT P
1953-7TH AVE., COLUMBUS 31901
SMITH,MALCOLM M. 42 R FP
SHAMROCK COURT APT., DUBLIN 31021
SMITH,MARTIN H. 34 ACT PD
274 ENOTA DR. NE, GAINESVILLE 30501
SMITH,MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD., BRUNSWICK 31520
SMITH,MIRIAM F. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033
SMITH,NAT E. 06 ACT I
MERCER UNIVERSITY, MACON 31201
SMITH,PATTON P. 06 ACT FP
235 MEDICAL COURT, FORSYTH 31029
SMITH,R. L. 50 ACT FP
COCHRAN 31014
SMITH,R. LOUIE 54 ACT I
1514 ANTHONY RD., AUGUSTA 30904
SMITH,REUBEN J. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
SMITH,RICHARD A. 29 ACT NS
35 COLLIER RD. NW, ATLANTA 30309
SMITH,RICHARD B. 29 ACT PD
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
SMITH,ROBERT B.,III 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
SMITH,ROBERT C. 72 ACT R
P. O. BOX 938, WAYCROSS 31501
SMITH,ROBERT R. 68 ACT SU
828 PINEY WOODS DR., LAGRANGE 30240
SMITH,ROBERT W. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
SMITH,ROBLEY D. 66 ACT FP
P. O. BOX 788, TIFTON 31794
SMITH,SAMUEL R. 17 ACT ANES
673 STEWART AVE. NW, MARIETTA 30060
SMITH,STEPHEN D. 27 ACT PD
10 HORSELEG CREEK RD., ROME 30163
SMITH,STUART A. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
SMITH,T. H. 56 DE5 OALR
3024 N. PATTERSON ST., VALDOSTA 31601
SMITH,THOS. H.,JR. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601
SMITH,W. P. 22 DE5 I
P.O. BOX 552, AVONDALE ESTATES 30002
SMITH,W. T. 02 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062
SMITH,WILLIAM A.,JR. 29 ACT OPH
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SMITH,WILLIAM JACKSON 30 ACT ANES
P.O. BOX 1518, BRUNSWICK 31520
SMITH,WILLIAM P.,JR. 10 ACT SU
BOWDON 30108
SMITH,WILLIAM S. 29 ACT OTO
490 PEACHTREE ST #347-B, ATLANTA 30308
SMITH,WILLIAM V. 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223
SMITH,WM. A. 29 DE5 N
35 COLLIER RD. NW, ATLANTA 30309
SMOOT,RICHARD H. 22 ACT SU
P.O. BOX 174, DECATUR 30030
SNEAD,JOSEPH A. 61 ACT OR
1102 E. LAMAR ST., AMERICUS 31709
SNITZER,JOSEPH A.,III 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305
SNYDER,WILLARD A. 30 ACT
2700 PARKWOOD DR., BRUNSWICK 31520
SODER,PARRY D. 29 ACT R
265 IVY ST. NE, ATLANTA 30303
SOLODAR,SEYMOUR O. 29 DE4 P
OAKLAND NAVAL HOSPITAL, OAKLAND,CAL. 94627
SOMERLOT,WARREN A. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
SOMERS,WM. H. 06 ACT R
P.O. BOX 6000, MACON 31208
SOMMERVILLE,MARGARET J. 02 ACT FP
90 W. WIEUCA RD. NE, ATLANTA 30342
SONES,PETER J. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
SORACCO,GERARDO J. 29 ACT TS
1311 CLEVELAND AVE., EAST POINT 30344
SORIANO,MARIA J. R. 29 ACT PD
35 COLLIER RD. NW, ATLANTA 30309
SORSDAHL,OLIVER A. 29 ACT R
300 BOULEVARD NE, ATLANTA 30312
SOSBY,JOHN T. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263
SOTUS,PETER C. 22 ACT SU
3606 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
SOUMA,JOHN A. 06 ACT OBG
P.O. BOX 6000, MACON 31208
SOUMA,MICKI C. 47 ACT OBG
P.O. BOX 951, COLUMBUS 31902
SOUTHER,JOE C. 03 ACT FP
802 E. BROAD ST., WINDER 30680
SOUZA,RENATO C. 16 ACT EM
274 SENOIA RD., FAIRBURN 30213
SOWELL,DAVID S. 29 ACT FP
2797 CAMPBELLTON RD., ATLANTA 30311

SOWELL,RAYMOND H.,JR. 11 ACT P
P.O. BOX N, POOLER 31322
SPANIER,JACOB A. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
SPANJER,RAYMOND F. 30 ACT FP
P.O. BOX 846, SEA ISLAND 31561
SPEAR,J. LOUIS 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501
SPEARMAN,WILLIAM B. 29 ACT I
1201 PEACHTREE ST., ATLANTA 30361
SPEARS,ROBERT S. 54 ACT ANES
809 KAMEL CIRCLE, AUGUSTA 30904
SPEARS,WENTFORD A. 36 ACT OALR
212 HOSPITAL DR., WARNER ROBINS 31093
SPENCER,WM. C.,III 29 ACT R
35 LINDEN AVE., ATLANTA 30308
SPERIOSU,S. U. 11 ACT P
1202 BRIGHTWOOD DR., SAVANNAH 31405
SPIVEY,HERMAN E. 27 ACT FP
COMMERCE ST., SUMMERVILLE 30747
SPIVEY,JAMES W. 36 ACT OR
124 HOSPITAL DR., WARNER ROBINS 31093
SPIVEY,OSCAR S. 06 ACT PD
2009 VINEVILLE AVE., MACON 31204
SPROUSE,JAMES H.,JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060
SPRUELL,WILLIAM H. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033
SREERAM,K. M. 06 ACT TS
700 SPRING ST., MACON 31201
ST. LOUIS,JOSEPH A.,JR. 29 ACT OPH
275 CARPENTER DR., ATLANTA 30328
STAATS,ETHAN F. 29 ACT OALR
35 COLLIER RD. NW, ATLANTA 30309
STACY,L. DAVID 29 ACT PATH
4575 N. SHALLOWFORD RD., CHAMBLEE 30341
STAHL,LOREN C. 06 ACT I
618 ORANGE ST., MACON 31201
STAHLKUPPE,ROBERT F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
STALEY,IRVING T. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
STAMBUK,ROBERT B. 08 ACT R
P. O. BOX 1048, STATESBORO 30458
STAMEY,CHARLES C. 47 ACT OBG
629 20TH ST., COLUMBUS 31906
STANCIL,MELODY ANN 17 ACT ANES
1805 ROSWELL RD., #3-F, MARIETTA 30060
STANLEY,CASSIUS M.,III 06 ACT U
839 1ST ST., MACON 31201
STAPLETON,GERALD M. 17 ACT OTO
2550 WINDY HILL ROAD, MARIETTA 30060
STAPLETON,JAMES W. 42 S OR
VA HOSPITAL, DUBLIN 31021
STAPLETON,JOHN L. 47 DE5 U
307 11TH ST., COLUMBUS 31901
STAPLETON,SIDNEY L.,JR. 29 ACT VS
914 CLIFTON RD.,NE, ATLANTA 30322
STAPLETON,SIDNEY L,JR 29 ACT VS

STAPLETON,TOMMY K. 18 ACT FP
WESTSIDE DR., DOUGLAS 31533
STAR,FRANKLIN J. 47 ACT SU
905 CENTER ST., COLUMBUS 31901
STARLING,ROBERT L. 21 ACT FP
MOSELEY CLINIC, DONALSONVILLE 31745
STARR,DONALD C. 17 ACT R
KENNESTONE HOSP., RADIOLOGY, MARIETTA 30060
STARR,HARLAN M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
STATHAM,GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021
STATON,JEAN STEWART 22 ACT I
2754 N. DECATUR RD., DECATUR 30033
STATON,TED L. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
STEADMAN,HENRY E. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
STEBLER,MICHAEL E. 72 ACT PATH
MEMORIAL HOSPITAL, WAYCROSS 31501
STECKER,DONALD C. 56 ACT
LOUIS SMITH MEM. HOSP., LAKELAND 31635
STEED,WILLIAM A. 54 ACT OALR
1122 DRUID PARK AVE., AUGUSTA 30904
STEELE,BYRON HAROLD 31 ACT FP
FAIRMOUNT 30139
STEGEMAN,JOHN F. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
STEIN,IGNATIUS J. 29 ACT SU
2391 SEWELL RD. SW, ATLANTA 30311
STEIN,J. D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
STEINBERG,DAVID L. 29 ACT
1285 PEACHTREE ST.,NE, ATLANTA 30309
STEINHAUER,JAMES J. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
STEINHAUS,JOHN E. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
STEPHENS,DAN B. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
STEPHENS,MARVIN R. 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501
STEPHENS,ROBERT O. 17 ACT PD
680 CHURCH ST., MARIETTA 30060
STEPHENSON,ROBERT H. 29 ACT SU
3250 HOWELL MILL RD. NW, ATLANTA 30327
STERGUS,INGRID 27 R PATH
316 MOUNT ALTO RD., ROME 30161
STEVENS,EDWARD L. 06 ACT OALR
800 FIRST STREET, MACON 31201
STEVES,ELMA M. 22 ACT PD
3624 CHAMBLEE TUCKER RD., CHAMBLEE 30341
STEVES,SEVERO 22 ACT OBG
204 PIKE ST., LAWRENCEVILLE 30245
STEWART,CALVIN B. 29 DE5 SU
478 PEACHTREE ST. NE, ATLANTA 30308
STEWART,CHARLES C. 21 ACT FP
P.O. BOX 371, DONALSONVILLE 31745
STEWART,CHARLES R. 47 ACT R
2807 NORRIS RD., COLUMBUS 31907
STEWART,DONALD M. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
STEWART,J. BENHAM 06 ACT SU
700 SPRING ST., MACON 31201
STILL,JOSEPH M.,JR. 54 ACT PL
MCG, AUGUSTA 30902
STINCER,ELPIDIO F. 02 ACT P
STATE HOSP., MILLEDGEVILLE 31061
STIVERS,ROBERT R. 29 ACT PATH
50 COCA COLA PLACE SE, ATLANTA 30303
STOCKS,S. ALLAN 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904
STODDARD,LELAND D. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902
STOKES,J. JACK 29 ACT OPH
478 PEACHTREE ST. NE, ATLANTA 30308
STONE,ALBERT LAWRENCE 16 ACT PD
1035 MAIN STREET, FOREST PARK 30050
STONE,CHARLES F.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
STONE,H. HARLAN 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
STONE,JOHN R. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060
STONE,R. L. 11 ACT ANES
5737 COLONIAL DRIVE, SAVANNAH 31406
STONE,WILLIAM D. 29 ACT
573 W. PEACHTREE ST. NE, ATLANTA 30303
STONER,CYRUS H. 29 DE5 OPH
340 BOULEVARD NE, ATLANTA 30312
STONER,W. P. 79 ACT FP
SYLVESTER 31791
STORY,JAMES L. 65 ACT SU
505 GORDON AVE., THOMASVILLE 31792
STOVALL,RUSSELL H.,JR. 22 ACT OTO
755 COLUMBIA DR., DECATUR 30030
STRAIGHT,GEORGE W. 11 ACT SU
319 E. HALL STREET, SAVANNAH 31401
STREIFF,IRWIN 11 ACT FP
BOX 6688, STA C, SAVANNAH 31405

STRESE,FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
STRETCHER,GEORGE S. 54 ACT D
MCG, AUGUSTA 30902
STRIBLING,WARREN DICKEY 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
STRICKLAND, W.E. 36 ACT
1120 MORNINGSIDE DR., PERRY 31069
STRICKLAND,AVERY W. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520
STRICKLER,C. W.,JR. 29 DE1 I
215 TOWNSEND PL. NW, ATLANTA 30327
STRICKLER,D. T.,JR. 10 ACT FP
P. O. BOX 518, DOUGLASVILLE 30134
STRICKMAN,BERNARD 17 ACT FP

STRITTMATTER,JAMES C. 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501
STROM,CARL H. 22 ACT PM
5040 SNAPFINGER WOODS DR., DECATUR 30032
STRONG,JAMES S. 54 ACT R
TALMADGE MEMORIAL HOSP., AUGUSTA 30904
STRONG,WILLIAM B. 54 ACT PDC
MED. COLLEGE OF GA., AUGUSTA 30902
STROUP,DAVID G. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30344
STUART,CARLOS A. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
STUART,WILLIAM H. 29 ACT I
25 PRESCOTT ST., ATLANTA 30308
STUBBS,JOE C. 56 ACT I
101 NORTHSIDE DR., VALDOSTA 31601
STUBBS,JOSEPH T.,JR. 11 ACT OPH
720 E. 71ST ST., SAVANNAH 31405
STUBBS,O. WYTCH,JR. 22 ACT FP
3628 CHAMBLEE TUCKER RD., CHAMBLEE 30341
STUBBS,TRAWICK H. 22 ACT PH
1287 OAKDALE RD., ATLANTA 30307
STUCK,ROBERT G. 34 ACT OR
MEMORIAL DR., DALTON 30720
STUCKEY,ANN D. 59 ACT PD
MEMORIAL DR., DALONEGA. 30533
STUCKEY,ANN D. 59 ACT PD

STUCKEY,KATHERINE 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
STUMP,ROBERT L.,JR. 56 ACT FP
1624 BOONE DR., VALDOSTA 31603
STURKIE,THOMAS OTIS 17 ACT OR
652 CHURCH ST., MARIETTA 30060
STURM,HIRAM MAXWELL 29 ACT D
401 PEACHTREE ST. NE, ATLANTA 30308
SU,SHAW C. T. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
SUAREZ,RAYMOND 06 DE5 FP
844 PARKVIEW DR., MACON 31201
SUIT,JAMES I. 29 I&R OPH
80 BUTLER ST.,SW, ATLANTA 30303
SULLIVAN,CARY E. 29 ACT PD
2555 CUMBERLAND PKWY, ATLANTA 30339
SULLIVAN,DANIEL B. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902
SULLIVAN,JAMES H. 47 ACT U
1430 3RD. AVE., COLUMBUS 31901
SULLIVAN,LOUIS W. 29 ACT I
223 CHESTNUT ST.,SW, ATLANTA 30314
SULLIVAN,ROBERT F. 28 ACT
CARNESVILLE 30521
SUMMEROUR,BROOKE F. 76 ACT ANES
P. O. BOX 252, DALTON 30720
SUMMERS,ROLAND S. 11 ACT I
P.O. BOX 5086, SAVANNAH 31403
SUNG,YUNG-FONG 29 ACT ANES
ANES DEPT, EMORY HOSP, ATLANTA 30322
SUSSMAN,HY C. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
SUTLIVE,WM. G. 11 ACT OBG
120 E. 34TH ST., SAVANNAH 31401
SUTTER,LUTHER O. 76 ACT FP
120 WALNUT, CHATSWORTH 30705

SUTTON,JAMES MACK,JR. 23 ACT PD
412 FOURTH AVE., ALBANY 31705
SWAIN,BRUCE 33 ACT FP
CLARKESVILLE 30523
SWANN,JULIAN W. 29 ACT D
490 PEACHTREE ST. NE, ATLANTA 30308
SWANSON,HOMER 29 R NS
1938 PEACHTREE RD. NW, ATLANTA 30309
SWEAT,MAXWELL J.,JR. 23 ACT PD
1007-1ST AVE., ALBANY 31701
SWIFT,CHARLES RAY 70 ACT PATH
3827 RINGGOLD RD., CHATTANOOGA, TN. 37412
SWIFT,JONATHAN S. 17 ACT OR
1422 CHEROKEE STREET, MARIETTA 30062
SWIFT,THOMAS R. 54 ACT N
MCG, DEPT. NEU, AUGUSTA 30902
SWILLING,EVELYN 06 R OB
844 PARKVIEW DR., MACON 31201
SWINGLE,ROGER L. 15 ACT OR
125 KING AVE., ATHENS 30601
SWINT,ROBERT H. 08 ACT SU
P. O. BOX 1088, STATESBORO 30458
SWISTERSKI,K. PETER 29 ACT ANES
20 LINDEN AVE. NE, ATLANTA 30308
SYMBAS,PETER 29 ACT TS
69 BUTLER ST. SE, ATLANTA 30303
SYN,WAI YUN 22 ACT I
2100 PARKLAKE DR. NE, ATLANTA 30345
SYRIBEYS,JOHN P. 22 ACT SU
3606 CHAMBLEE-TUCKER RD., CHAMBLE, 30341

T

TABATABAI,JAFAR 17 ACT PATH
P.O. BOX 665, MABLETON 30059
TAIT,C. DOWNING,JR. 29 ACT P
820 DOUGLAS RD. NE, ATLANTA 30342
TAKLE,LEIV M. 59 ACT OPH
646 S. 8TH ST., GRIFFIN 30223
TALBERT,WILLIAM G.,JR 36 DE5 FP
212 HOSPITAL DR., WARNER ROBINS 31093
TALBOTT,GEORGE D. 22 ACT I
500 WINN WAY, DECATUR 30030
TALLEDO,O. EDUARDO 54 ACT OBG
MED COLLEGE OF GA., AUGUSTA 30904
TALLEY,J. LECONTE,JR. 23 ACT OBG
901 N. MADISON ST., ALBANY 31705
TALLEY,ROBERT E. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901
TALMADGE,HARRY E. 15 ACT SU
489 N. MILLEDGE AVE., ATHENS 30601
TAMAYO,PEDRO L. 02 ACT OR
BOX 714, MILLEDGEVILLE 31061
TAN,HO T. 61 ACT ANES
P.O. BOX 1105, AMERICUS 31709
TANENBAUM,JULIAN B. 54 ACT PD
2315 CENTRAL AVE., AUGUSTA 30904
TANKESLEY,ROBERT M. 71 ACT R
437 PLANTATION DR., MONROE 30655
TANNER,DAVID E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
TANNER,GEO. E. 42 ACT SU
606 ACADEMY AVE., DUBLIN 31021
TANNER,JACK E. 17 ACT OBG
1200 ROSWELL RD., MARIETTA 30060
TANNER,JAMES C.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
TANNER,MAURICE B. 65 ACT R
PO BOX 1001, THOMASVILLE 31792
TANNER,ROBERT E. 54 ACT
1467 HARPER ST., AUGUSTA 30902
TANNER,TERRELL B. 48 ACT FP
110 CLARKE STREET, OXFORD 30267
TARANTO,ALAN I. 29 ACT I
5675 P'TREE-DNWDY RD, 510, ATLANTA 30342
TARANTO,MORRIS B. 29 ACT FP
727 W. PEACHTREE STREET NE, ATLANTA 30308
TARCAN,YAVUZ A. 29 A I
80 BUTLER ST. SE, ATLANTA 30303

TARRANT,GRACE L. 06 ACT R
MEDICAL CENTER, MACON 31201
TATE,JOHN DREWRY 27 ACT FP
MCCALL CLINIC, ROME 30161
TATUM,JOSEPH C. 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
TATUM,L. L.,JR. 59 ACT U
653 S. 8TH ST., GRIFFIN 30223
TAUBER,CHARLES P. 29 ACT P
415 E.PACES FERRY RD. NE, ATLANTA 30305
TAYLOR,DAVID M. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
TAYLOR,HOWARD P. 30 DE5 FP
COTTAGE 218, SEA ISLAND 31561
TAYLOR,JAMES P. 65 ACT OBG
507 GORDON AVE., THOMASVILLE 31792
TAYLOR,JAMES W. 72 ACT OPH
P.O. BOX 778, WAYCROSS 31501
TAYLOR,JOHN EDWIN,JR. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021
TAYLOR,ROBERT P. 17 ACT OPH
615 ROSWELL STREET, MARIETTA 30060
TAYLOR,TERRY W. 29 ACT OPH
960 JOHNSON FERRY ROAD NE, ATLANTA 30342
TAYLOR,THOMAS B. 10 ACT
DOUGLASVILLE 30134
TAYLOR,WARREN A. 65 ACT SU
PROF. BLDG. SIEXAS ST., THOMASVILLE 31792
TAYLOR,WILLIAM E. 74 I&R FP
SMITH ST., TENNILLE 31089
TAYLOR,WILLIAM J. 29 ACT FP
2049 PERKERSON RD. SW, ATLANTA 30310
TAYLOR,WILLIAM M. 47 ACT R
MEDICAL CENTER, COLUMBUS 31902
TEAFORD,HENRY ST.GEORGE,JR. 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
TEAL,C. B.,JR. 13 DE5 I
HALL CO HLTH DEPT, BOX 1295 GAINESVL 30501
TEATE,H. LUTEN,JR. 22 ACT PD
1901 CENTURY BLVD. NE, ATLANTA 30345
TEEM,M. V. B. 17 ACT I
200 CHEROKEE STREET, MARIETTA 30060
TEEM,MARTIN V.,JR. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060
TEESLINK, C. REX 54 ACT R
1467 HARPER ST., AUGUSTA 30902
TEH,JACK B. 76 ACT PATH
HAMILTON MEM HOSP,PO BOX 1168, DALTON 30720
TEKIN,MAHIR 29 ACT ANES
3240 JETT FERRY CT. NE, DUNWOODY 30338
TEMPLES,POWELL M.,JR. 29 DE4 P
209 EERIE AVE, DECATUR 30033
TENEBAUM,STANLEY M. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084
TEPLIS,PAUL 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
TERRELL,JOE F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
TERRELL,WARREN 70 ACT ANES
1719 JOHN ROSS RD., CHATTANOOGA.,TN 37412
TERRY,D.B. 72 ACT FP
HOMERVILLE 31634
TERRY,DANIEL B.,JR 72 ACT SU
403 LISTER ST, WAYCROSS 31501
TERRY,JULES S. 29 A OBG
47 TRINITY AVE., ATLANTA 30334
TETHER,ROBERT S. 34 ACT SU
194 GOLD ST. NE, GAINESVILLE 30501
THAGARD,ROY FRANK 30 ACT PD
2601 PARKWOOD DRIVE, BRUNSWICK 31520
THAKRAR,B.D. 33 ACT SU
BOX 696, DEMOREST 30535
THAKRAR,CHANDRAKA B. 33 ACT ANES
P.O. BOX 696, DEMOREST 30535
THAMES,FRANK M.,JR. 33 ACT FP
BOX 367, DEMOREST 30535
THEBAUT,BEN R. 29 ACT SU
960 JOHNSON FERRY RD,NE,405, ATLANTA 30342
THEUS,THOMAS L. 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901
THIBODEAUX,DAVID C. 17 ACT R
70 TOWER RD. NW, MARIETTA 30062
THIGPEN,CORBETT H. 54 ACT P
1423 HARPER ST., AUGUSTA 30902
THITARAM,SOMPHONG 29 ACT SU
2351 BOLTON RD,NW, ATLANTA 30318
THOMAS,DAVID R.,III 54 ACT PUL
1467 HARPER ST #208, AUGUSTA 30902
THOMAS,DAVID R.,JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
THOMAS,DONALD RAY 76 ACT FP
1714 CLEVELAND RD., DALTON 30720
THOMAS,FRANK E. 23 DE1 PD
12 SHERWOOD RD NW, FT. WALTON, FLA 32548
THOMAS,KENNETH E. 29 ACT SU
1938 PEACHTREE RD. NW, ATLANTA 30309
THOMAS,LUTHER M.,JR. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904
THOMAS,R. P. 54 ACT OPH
3651 WHEELER RD.,STE.100, AUGUSTA 30904
THOMAS,RUSSELL 61 DE1
131 SOUTH JACKSON STREET, AMERICUS 31709
THOMAS,WILLIAM K. 29 I&R OPH
80 BUTLER ST.,SE, ATLANTA 30303
THOMASON,W. L. 29 DE5 SU
1272 BREEZY LN. NE, ATLANTA 30329
THOMASSON,GEORGE O. 15 ACT CH
P. O. BOX 8043, ATHENS 30601
THOMASSON,JAMES J.,JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263
THOMPSON,CLEVELAND,III 72 ACT SU
410 ZACHRY ST., WAYCROSS 31501
THOMPSON,CLEVELAND,JR. 09 DE1 FP
RT 2 BOX P-47 F, SANTEE, SC 29142
THOMPSON,D. O. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
THOMPSON,E. F. 56 DE5 OALR
DOCTORS BUILDING, VALDOSTA 31603
THOMPSON,EMORY F. 56 ACT OALR
DOCTORS BUILDING, VALDOSTA 31603
THOMPSON,F. H. 61 ACT PATH
AMERICUS 31709
THOMPSON,HUGH S.,JR. 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344
THOMPSON,JAMES W. 15 ACT I
220 N. MILLEDGE AVENUE, ATHENS 30601
THOMPSON,JOHN D. 29 ACT OBG
69 BUTLER ST., SE, ATLANTA 30303
THOMPSON,JOHN W. 29 DE1 PD
3814 VERMONT RD. NE, ATLANTA 30319
THOMPSON,JOSIAH 08 ACT SU
MCKINLEY & SMITH STS., CLAXTON 30417
THOMPSON,RAMON C. 15 ACT U
225 S. MILLEDGE, ATHENS 30601
THOMPSON,ROBERT E. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
THOMPSON,ROBERT F. 20 ACT OALR
P.O. BOX 1155, NEWNAN 30263
THOMPSON,WILBUR J. 34 ACT OBG
1144 VINE ST. NE, GAINESVILLE 30501
THOMPSON,WILLIAM R. 31 ACT
5000 SNAPFINGER WDS DR, DECATUR 30032
THOMPSON,WILLIAM R. 29 ACT OBG
1691 CANDLER ROAD, DECATUR 30032
THORNTON,H. A. 49 ACT FP
P. O. BOX 326, GREENSBORO 30642
THORNTON,NANCY 54 ACT PD
VA HOSP., AUGUSTA 30904
THORNTON,NATHANIEL A. 29 ACT I
400 COLONY SQUARE #1605, ATLANTA 30361
THORNTON,NATHANIEL A. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
THRASH,CALVIN L.,JR. 47 ACT I
2039 WARM SPRINGS RD., COLUMBUS 31901
THRASHER,BARRIE H.,JR. 29 ACT OPH
3280 HOWELL MILL RD NW #307, ATLANTA 30327
THREEFOOT,SAM A. 54 ACT I
DEPT MED TULANE UNIV, NEW ORLEANS, LA 70112
THRELKELD,WILLIAM A. 56 ACT P
P. O. BOX 1727, VALDOSTA 31603

THRONE,MARTIN L. 29 ACT I
3648 CHAMBLEE-TUCKER RD., CHAMBLEE 30340
THURMOND,A. G. 54 ACT OBG
524 GEORGIA AVE., N. AUGUSTA, S. C. 29841
THURMOND,GEORGE W. 54 ACT OTO
2283 WRIGHTSBORO RD., AUGUSTA 30904
THURMOND,J. W. 54 DE5 OBG
1167 UNIVERSITY PL., AUGUSTA 30902
THWAITE,WALTER G. 29 A OBG
69 BUTLER ST. SE, ATLANTA 30303
TIDMORE,THOMAS L.,JR. 29 ACT ANES
1405 CLIFTON RD. NE, ATLANTA 30322
TIDWELL,OWEN K. 68 ACT R
CITY-COUNTY HOSP., LA GRANGE 30240
TIDWELL,REX W. 06 ACT R
380 HOSP. DR., MACON 31201
TIFT,HENRY H. 06 ACT I
765 SPRING ST., MACON 31201
TILIACOS,JOHN N. 17 ACT OR
104 BEVERLY HILLS DR., MARIETTA 30062
TILLERY,WM. V.,III 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904
TILLINGER,ARNOLD J. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405
TILLMAN,BILLUPS P. 15 ACT OR
125 KING AVE., ATHENS 30601
TILLMAN,RALPH A. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30030
TILLMAN,SAMUEL P. 08 ACT I
302 DONEHOO ST., STATESBORO 30458
TIMBERLAKE,G. B. 29 ACT SU
133 CARNEGIE WAY NW, ATLANTA 30303
TIMBERLAKE,LLOYD F. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
TIMMS,DICKY W. 11 ACT SU
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
TINDALL,GEORGE T. 22 ACT N
1365 CLIFTON RD., ATLANTA 30322
TINDALL,HARRY C. 29 ACT OPH
1938 PEACHTREE RD. NW, ATLANTA 30309
TINDALL,SUZIE C. 22 ACT N
DECATUR N. PROF. BLDG., DECATUR 30030
TIPPINS,WM. C.,JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30030
TODD,CHARLES E.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
TODD,JOHN M. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
TODINO,JOEL D. 27 ACT I
HARBIN CLINIC, ROME 30161
TOMAS,TEOFILO 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
TOOLE,JAMES C. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
TOOLE,WM. NISBET 29 ACT U
6500 VERNON WOODS RD. NE, ATLANTA 30328
TOOTLE,GEORGE S. 13 ACT SU
P.O. BOX 35, DULUTH 30136
TOOTLE,JERRY C. 13 ACT SU
P.O. BOX 746, DULUTH 30136
TOPOROFF,STUART J. 29 ACT I
265 IVY ST. NE, ATLANTA 30303
TORNOW,ABRAHAM M. 29 S GE
1670 CLAIRMONT RD. NE, DECATUR 30030
TORRES,SAMUEL A. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
TOVAR-DE-HOYOS,MANUEL 56 ACT FP
2311 N. PATTERSON ST., VALDOSTA 31601
TOWNSEND,ROBERT M. 17 ACT FP
627 CHEROKEE ST., MARIETTA 30060
TRACY,J. L.,JR. 79 ACT FP
SYLVESTER 31791
TRAIN,JOHN KIRK,JR. 11 ACT ALR
1107 BULL ST., SAVANNAH 31401
TRAYLOR,JAMES BOTHWELL 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
TRAYLOR,S. B. 59 ACT FP
BARNESVILLE 30204
TRENT,R. M. 22 ACT FP
2054 LAWRENCEVILLE HWY, DECATUR 30033
TREST,FRED A. 54 ACT P
MEDICAL COLLEGE OF GA, AUGUSTA 30902
TREVEJO,WILLIAM A. 65 ACT ANES
1616 E. WASHINGTON ST., THOMASVILLE 31792
TRIANA,CARLOS R. 72 ACT SU
PATTERSON 31557
TRICE,JOHN C. 15 ACT P
150 TALMADGE DR., ATHENS 30601
TRIPPE,JUDSON R.,JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060
TROTTER,JOHN F. 22 ACT FP
2054 LAWRENCEVILLE HIWAY., DECATUR 30033
TRULOCK,ALBERT S.,JR. 23 ACT SU
800 N. JEFFERSON ST., ALBANY 31701
TSAO,SHU-YUN T. 15 ACT PD
698 S. MILLEDGE AVE., ATHENS 30601
TSENG,GEORGE Y. 50 ACT PD
1009 N. MONROE ST., ALBANY 31701
TUCK,ALBERT C.,DDS 65 AF
P.O. BOX 978, THOMASVILLE 31792
TUCK,G. G. 48 ACT FP
P.O. BOX 1058, COVINGTON 30209
TUCKER,JOHN P. 19 ACT FP
300 13TH AVE. SW, MOULTRIE 31768
TUCKER,R. P. 29 ACT SU
1603 WARE AVE., EAST POINT 30344
TUGGLE,M. VIRGINIA 22 ACT I
1336 COLUMBIA DR., DECATUR 30032
TUMLIN,WILLIAM D. 15 ACT FP
LEXINGTON 30648
TURCOTTE,MAURICE R. 29 ACT
P.O. BOX 768, EAST POINT 30344
TURK,L. N.,JR. 37 ACT SU
P. O. BOX 52, HOMER 30547
TURK,L. NEWTON,III 29 ACT TS
35 COLLIER RD. NW, ATLANTA 30309
TURNER,AUGUST B. 29 ACT SU
384 PEACHTREE ST. NE, ATLANTA 30308
TURNER,CORBETT H. 29 ACT P
EMORY UNIV. CLINIC, ATLANTA 30322
TURNER,DANIEL R. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
TURNER,DAVID A. 23 ACT P
420 4TH ST., ALBANY 31705
TURNER,DON W. 22 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
TURNER,H. H. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
TURNER,J. R. 68 ACT
LAGRANGE 30240
TURNER,JOHN S.,JR. 29 ACT OALR
1388 COUNCIL BLUFF DR.,NE, ATLANTA 30345
TURNER,JOHN W. 29 DE5 SU
384 PEACHTREE ST., ATLANTA 30308
TURNER,JOSEPH M. 66 ACT I
P. O. BOX 983, TIFTON 31794
TURNER,RICHARD J. 60 ACT
P.O. BOX 746, CLAYTON 30525
TURRENTINE,PAUL E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
TUTEN,CARROLL 30 ACT OPH
3011 KEMBLE AVE., BRUNSWICK 31520
TUTSCH,WILBERT R. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
TUTTLE,ELBERT P.,JR. 29 A I
69 BUTLER ST. SE, ATLANTA 30303
TYLER,HERBERT D. 69 ACT I
P.O. BOX 710, THOMASTON 30286
TYLER,RICHARD M. 29 ACT OR
2351 BOLTON RD. NE, ATLANTA 30318
TYRONE,NELSON O.,JR. 47 ACT U
717-20TH ST., COLUMBUS 31904

U

UEHLING,EDWARD R. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033
UHL,LAWRENCE W. 29 ACT PD
6043 NAVAHO TR., MORROW 30260

ULLMAN,KARL H. 29 ACT I
1311 CLEVELAND AVE., EAST POINT 30344
UNDERWOOD,CHARLES R. 17 ACT SU
641 CHURCH ST., MARIETTA 30060
UNDERWOOD,FRANK O. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
UPCHURCH,W. E. 29 DE5 U
98 CURRIER ST. NE, ATLANTA 30308
UPSHAW,CHARLES B.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
UPSON,E. T. 29 R SU
RT. 7, BOX 241, CUMMING 30130
URRUTIA,R.V.,JR. 17 ACT OR
1244 STONEVIEW DR., MARIETTA 30062
USHER,CHARLES JR. 11 ACT NS
6 E. LIBERTY ST., SAVANNAH 31401
UTLEY,HENRY G. 15 ACT OPH
759 COBB ST., ATHENS 30601

V

VALBUENA,D. A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
VALDECANAS, VIRGILIO 02 ACT SU
P.O. BOX 1151, MILLEDGEVILLE 31061
VALDERRAMA,HUGO 29 ACT PATH
731 W. PEACHTREE ST.,NE, ATLANTA 30308
VALENTE,L. A. 30 ACT SU
1801 REYNOLDS STREET, BRUNSWICK 31520
VALENTINE,H. E.,JR. 34 ACT I
429 SPRING ST. SE, GAINESVILLE 30501
VAN BUREN,E. 29 DE5 I
768 JUNIPER ST. NE, ATLANTA 30308
VAN BUREN,JAMES K. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
VAN DE WETERING,R. J. 29 ACT P
5675 PEACHTREE-DNWDY RD NW, ATLANTA 30342
VAN DEVENTER,PHILLIP 23 ACT ANES
P.O. BOX 1828, ALBANY 31702
VAN DUYN,JOHN 47 DE5 PL
DOCTORS BLDG., COLUMBUS 31901
VAN DYKE,PAUL B. 30 DE5 FP
P.O. DRAWER N, BRUNSWICK 31520
VAN GIESEN,GEO. E.,JR. 54 ACT I
3623 DEWEY GRAY CIR., AUGUSTA 30904
VANDERBURGH,ALEXANDER 15 A FP
517 HAMPTON CT., ATHENS 30602
VANDERPOOL,GERALD E. 17 ACT AL
2480 WINDY HILL ROAD, MARIETTA 30062
VANDERZALM,THEODORA 54 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
VANDIVER,ROY W. 22 ACT N
365 WINN WAY, DECATUR 30030
VANSANT,CLAUDE V.,SR. 10 DE5 FP
P.O. BOX 1195, DOUGLASVILLE 30134
VANSANT,CLAUDE V.,SR. 10 DE5 FP
DOUGLASVILLE 30134
VANSANT,T. J.,JR. 17 ACT I
P. O. BOX 1287, MARIETTA 30062
VARNER,JOHN B. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
VARNER,W. D. 47 ACT OBG
2300 MANCHESTER RD., COLUMBUS 31904
VASCONEZ,LUIS O. 29 ACT PL
1365 CLIFTON RD., ATLANTA 30322
VASKO,TRUMAN L. 26 ACT SU
P.O. BOX 247, VIENNA 31092
VASSEY,G. C. 70 ACT FP
791 CHICAMAUGA AVE., ROSSVILLE 30741
VAUGHAN,EDGAR ALLEN 17 ACT
74 MEDICAL SQUARE, MARIETTA 30060
VAUGHAN,R. H. 47 ACT SU
711 CENTER, COLUMBUS 31901
VAUGHAN,WILLIAM L. 44 ACT SU
KNOX PLAZA, THOMSON 30824
VEAL,CURTIS F. 02 ACT FP
P.O. BOX 489, MILLEDGEVILLE 31061
VEATCH,J. W.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
VELKOFF,ABRAHAM S. 29 ACT OBG
1175 PEACHTREE ST. NE, ATLANTA 30309
VENABLE,JAMES HEISKELL 47 ACT OBG
2300 MANCHESTER RD., COLUMBUS 31904
VENABLE,JOHN H. 29 A PH
2418 HOWELL MILL RD.,NW, ATLANTA 30318
VENABLE,ROBERT N. 26 ACT FP
403 15TH AVE., CORDELE 31015
VERLEY,KARL W. 29 ACT OBG
2945 STONE HOGAN RD. SW, ATLANTA 30331
VEVERKA,FRANK 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
VICKERY,S. A. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529
VICTOR,IRVING 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
VICTOR,JULES,JR. 11 ACT I
P. O. BOX 6336, SAVANNAH 31405
VICTOR,SAMUEL 72 ACT FP
300 PINEVIEW DR., WAYCROSS 31501
VIGIL,RAMON A. 16 ACT ANES
409 ARROWHEAD BLVD, BLDG A, JONESBORO 30236
VIGRASS,HOWARD G. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902
VILLANUEVA,L. S. 17 ACT P
1676 MULKEY RD., AUSTELL 30001
VINSON,FRANK 36 DE5 FP
FORT VALLEY 31030
VINSON,T. O. 22 ACT PH
440 WINN WAY, DECATUR 30030
VINTON,L. M.,JR. 22 ACT FP
1043 LAKESHORE DR., AVONDALE ESTATES 30002
VIRUSKY,E. J. 01 ACT SU
N. MAIN ST., BAXLEY 31513
VISINTINE,AAROLYN M. 29 A PD
69 BUTLER ST. SE, ATLANTA 30303
VITNER,SAUL 29 ACT OBG
275 CARPENTER DR. NE, ATLANTA 30328
VOGLER,WM. R. 22 ACT I
2057 CLAIRMONT RD., DECATUR 30033
VOHMAN,MANN DARIUS 29 ACT PATH
1968 PEACHTREE RD. NW, ATLANTA 30309
VOLJAVEC,BOZIDAR F. 29 ACT FP
1311 CLEVELAND AVE., EAST POINT 30344
VOLPITTO,P. P. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902
VON HAAM,EMMERICH,JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344
VOYLES,WALTER R. 09 ACT SU
307 FOURTH ST., WAYNESBORO 30830

W

WADDELL,PEARL B. 30 R PD
1631 LAWTON LANE, LAKELAND, FLA 33803
WADE,JOHN S. 11 ACT SU
122 E. GASTON ST., SAVANNAH 31401
WADE,LEO J. 49 ACT FP
208 VEASEY ST., UNION POINT 30669
WADE,ROBERT C. 22 ACT
3371 COLUMBIA WOODS DR., DECATUR 30032
WADE,V. C. 61 ACT FP
1102 E. LAMAR ST., AMERICUS 31709
WADSWORTH,GERALD E. 29 ACT OPH
478 PEACHTREE ST. NE, ATLANTA 30308
WAGES,HARVEY S.,JR. 76 ACT OBG
MEDICAL ARTS BLDG., DALTON 30720
WAGES,TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518
WAGGONER,DAVID C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
WAITS,EDWARD JONES 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WAKEFIELD,JOHN R. 17 ACT
2404 MARIETTA RD., AUSTELL 30001
WALDEMAYER,E. W. 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709
WALDEN,CHARLES W. 22 ACT P
1989 N. WILLIAMSBURG DR., DECATUR 30033

WALDREP,JACK MARION 27 ACT U
101 JOHN MADDOX DR., ROME 30161
WALKER,C. J.,JR. 34 ACT FP
242 ENOTA DR. NE, GAINESVILLE 30501
WALKER,CHARLES O. 21 ACT SU
SEMINOLE MEM. HOSP., DONALSONVILLE 31745
WALKER,DUNCAN,JR. 06 ACT ALR
700 SPRING ST., MACON 31201
WALKER,GEO. L. 59 R
709 MAPLE DR., GRIFFIN 30223
WALKER,GEORGE S.,III 50 ACT I
GRIFFIN ST.,PROF.CNTR., EASTMAN 31023
WALKER,HENRY K. 29 A I
80 BUTLER ST. SE, ATLANTA 30303
WALKER,JAMES A. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
WALKER,JEROME M.,JR. 22 ACT N
755 COLUMBIA DR., DECATUR 30030
WALKER,JOHN H. 54 ACT PATH
VA HOSPITAL, AUGUSTA 30904
WALKER,JOHN R. 29 DE5 SU
922 W. PTREE ST., ATLANTA 30309
WALKER,JOHN W. 22 ACT OBG
365 WINN WAY, DECATUR 30030
WALKER,KNOX,JR. 22 ACT OR
1405 CHURCH ST., DECATUR 30030
WALKER,LEO L.,JR. 29 A I
2417 BERMUDA HILLS RD., COLUMBIA, SC 20204
WALKER,MOFFETT R.,JR. 22 ACT I
BOX 3210, ATLANTA 30302
WALKER,OTTIS 76 ACT FP
W. WALNUT AVE., CHATSWORTH 30705
WALKER,ROBERT J.,III 29 ACT R
960 JOHNSON FERRY RD.,NE, ATLANTA 30342
WALKER,ROBERT J.,JR. 06 A PH
770 HEMLOCK ST., MACON 31201
WALKER,W. W.,III 22 ACT OBG
365 WINN WAY, DECATUR 30030
WALLACE,BILL L. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30060
WALLACE,ROBERT G. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
WALLACE,RUSSELL W.,JR. 22 ACT N
755 COLUMBIA DR., DECATUR 30030
WALLACE,STUART M. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403
WALLER,JAMES T. 11 ACT I
P.O. BOX 6688, STA. C, SAVANNAH 31405
WALLER,ROBERT D. 23 ACT R
P.O. BOX 1924, ALBANY 31702
WALLER,ROY M.,JR. 47 ACT FP
203 PHYSICIANS BLDG., COLUMBUS 31901
WALSH,W. MICHAEL 47 I&R
105 DOCTORS BUILDING, COLUMBUS 31901
WALTER,AUSTIN J. 33 ACT FP
SAUTEE 30571
WALTER,JONNE B. 29 A I
300 BOULEVARD NE, ATLANTA 30312
WALTER,R. D. 31 ACT FP
CALHOUN 30701
WALTERS,GORDON E. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904
WALTON,KENNETH N. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
WALZ,PETER D. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033
WAMMOCK,HOKE 68 ACT SU
ENOCH CALLAWAY CANCER CLN, LAGRANGE 30240
WAMMOCK,VIRGENE S. 68 ACT D
771 LAKEWOOD DR., LA GRANGE 30240
WARD,CHARLES J. 22 ACT OBG
365 WINN WAY, DECATUR 30030
WARD,CHARLES M. 53 ACT FP
107 1/2 LEE STREET, DAWSON 31742
WARD,DANIEL F. 54 ACT P
3651 WHELER RD., AUGUSTA 30904
WARD,EUGENE L. 34 ACT OALR
P. O. BOX 13, GAINESVILLE 30501
WARD,JAMES 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901
WARD,JOHN ALBIN 29 S
1670 CLAIRMONT RD. NE, ATLANTA 30329
WARD,M. CAROLYN 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062
WARD,M. TERRY 29 ACT EM

WARD,MARY C. 17 ACT PD
652 CHURCH ST., MARIETTA 30060
WARD,RICHARD S. 29 ACT P
EMORY UNIV., ATLANTA 30322
WARD,WILLIAM T.,JR. 22 ACT FP
231 E PONCE DE LEON AVE., DECATUR 30030
WARD,WM. C. 29 ACT SU
2292 FAIRBURN RD. SW, ATLANTA 30331
WARKENTIN,JOHN 29 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
WARNER,CLINTON E. 29 ACT SU
319 W. LAKE AVE. NW, ATLANTA 30318
WARNER,JOHN C.,JR. 17 ACT PD
3001 S. COBB DR. SE, SMYRNA 30080
WARNER,WM.,PHILIP,JR. 29 ACT OR
35 COLLIER RD. NW, ATLANTA 30309
WARNICK,LILLIAN P. 17 ACT PH
12 CAPITOL SQUARE NE, ATLANTA 30334
WARNOCK,RALPH P. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
WARREN,CECIL D. 29 ACT
1143 BANBURY CROSS, AVONDALE ESTATES 30002
WARREN,HOWELL R. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
WARREN,W. C.,JR. 29 DE5 ALR
490 PEACHTREE ST. NE, ATLANTA 30308
WARREN,WALTER D. 29 ACT SU
1364 CLIFTON RD. NE, ATLANTA 30322
WASDEN,HOWELL A. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
WASHBURN,LAWRENCE,JR. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
WASSERMAN,STANLEY B. 29 ACT PD
99 BUTLER ST,SE, ATLANTA 30303
WATERS,A. J. 54 ACT ANES
3405 SASANQUA DR., AUGUSTA 30904
WATERS,DONALD B. 72 ACT FP
BLACKSHEAR 31516
WATERS,JAMES L.,JR. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WATERS,LAMAR H. 33 ACT I
BOX 305, CLARKESVILLE 30523
WATERS,RAYMOND O. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
WATERS,WM. C.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
WATKINS,CHARLES B. 22 ACT FP
3543 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
WATKINS,JAMES W.,JR. 29 ACT SU
P.O. BOX 314, RIVERDALE 30274
WATKINS,W. LORRAINE 29 ACT PD
315 BOULEVARD,NE, ATLANTA 30312
WATKINS,W. M. 42 ACT SU

WATRAS,CHARLES S. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
WATSON,DAVID T. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
WATSON,DAVIS RONALD 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901
WATSON,EDWIN R. 06 ACT PD
745 PINE ST., MACON 31201
WATSON,FRANCIS M.,JR. 29 ACT OR
1938 PEACHTREE RD #603, ATLANTA 30309
WATSON,JOHN D.,JR. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
WATSON,W. G. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902
WATT,CHARLES H.,JR. 65 ACT SU
900 GORDON AVE., THOMASVILLE 31792
WATT,WILLIAM VANCE 65 ACT SU
900 GORDON AVENUE, THOMASVILLE 31792
WATTERS,JULIAN Q. 29 ACT PD
5675 PTREE-DUNWOODY RD. N.E., ATL 30342

WATTS,JERALD L. 34 ACT OR
710 BROAD STREET, SE, GAINESVILLE 30501
WAXLER,EDWARD B. 72 ACT I
P.O. BOX 899, WAYCROSS 31501
WEAVER,ALEXANDER H. S. 06 ACT OR
P. O. BOX 6317, MACON 31208
WEAVER,JERRY O. 27 ACT FP
502 N. MAIN ST., CEDARTOWN 30125
WEAVER,WILLIAM H. M. 06 ACT I
700 SPRING STREET, MACON 31201
WEAVER,WILLIAM T. 29 ACT TS
340 BOULEVARD NE, ATLANTA 30312
WEBB,RAY D. 11 ACT FP
SPRINGFIELD 31329
WEBBER,JOSEPH M. 47 ACT PATH
633-19TH ST., COLUMBUS 31901
WEBSTER,BRUCE S. 60 ACT EM
RT. 3, BOX 399-A, TOCCOA 30577
WEBSTER,PAUL D.,III 54 ACT GE
MED. COLLEGE OF GEORGIA, AUGUSTA 30902
WEBSTER,ROBERT M. 29 ACT FP
2888 BAYARD ST, EAST POINT 30344
WEBSTER,ROBERT M. 29 ACT FP
2415 FAIRBURN RD. SW, ATLANTA 30331
WEEKS,RICHARD B. 54 DE1 SU
4230 13TH ST, ST SIMONS ISLAND 31522
WEEMS,H. E.,JR. 36 ACT FP
PERRY 31069
WEENS,H. S. 29 ACT R
80 BUTLER ST. SE, ATLANTA 30303
WEIGLE,KEITH E. 50 ACT R
DODGE COUNTY HOSPITAL, EASTMAN 31023
WEIHE,JAMES H. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30902
WEINBERG,SEYMOUR PAUL 29 ACT OBG
384 PEACHTREE STREET NE, ATLANTA 30308
WEISMAN,EVAN B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060
WEISMAN,H. JAY 13 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
WEISS,EDWARD A. 30 DE4 N
USAF HOSP BOX 7214, EGLIN AFB FL. 32542
WEISS,HARVEY A. 29 ACT PL
6500 VERNON WOODS DR. NE, ATLANTA 30328
WELCH,ANDREW J. 29 A OR
300 BOULEVARD NE, ATLANTA 30312
WELLS,DAVID A. 76 ACT FP
1219 MEMORIAL DR., DALTON 30720
WELLS,JAMES M. 06 DE1 ANES
2983 VICTORIA DR., MACON 31201
WELLS,JOHN A. 06 ACT SU
724 HEMLOCK ST., MACON 31201
WELLS,JOHN G. 20 ACT I
P.O. BOX 1099, NEWNAN 30263
WELLS,ROBERT E. 29 ACT OR
1938 PEACHTREE RD. NW, ATLANTA 30309
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WELTER,DONALD J. 54 ACT FP

WENGER,JULIUS 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
WENGER,NANETTE K. 29 A
80 BUTLER ST. S. E., ATLANTA 30303
WERNER,JACQUELINE H. 16 ACT PATH
11 S.W. UPPER RVRDALE RD., RVRDALE 30274
WEST,J. HERBERT 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WEST,JOHN H. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406
WEST,ROBERT M. 29 ACT
1134 MAIN ST., FOREST PARK 30050
WESTERFIELD,C. W. 11 ACT ANES
801 GOEBEL AVE., SAVANNAH 31404
WETHERBY,DAVID 58 ACT
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WHALEY,MORGAN N. 44 ACT FP
312 HOSPITAL DRIVE, THOMSON 30824
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WHALEY,WILLIAM H. 29 ACT I
3250 HOWELL MILL RD.,NW, ATLANTA 30327
WHATLEY,E. C. 61 ACT
REYNOLDS 31076
WHATLEY,GEORGE S. 47 ACT OR
2009 WARM SPRINGS RD., COLUMBUS 31904
WHATLEY,LEWIS R. 04 DE1 FP
38 GREEN ST., CARTERSVILLE 30120
WHATLEY,WILLIAM B. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
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3020 SHRINE RD., BRUNSWICK 31520
WHELAN,EDWARD J. 11 ACT U
2113 BULL STREET, SAVANNAH 31401
WHELCHEL,MERRITT C. 54 ACT OPH
905 15TH ST, #E, AUGUSTA 30902
WHIDDER,DESIDERIUS C. 29 ACT SU
490 PEACHTREE ST., ATLANTA 30308
WHIDDON,C. MAURICE 11 ACT SU
122 E. GASTON ST., SAVANNAH 31404
WHIPPLE,ROBERT L.,III 29 ACT I
3280 HOWELL MILL RD NW #125, ATLANTA 30327
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1999 CLIFF VALLEY WAY NE, ATLANTA 30329
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HOUSTON COUNTY HOSP., WARNER ROBINS 31093
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629 20TH ST., COLUMBUS 31902
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WHITE,HENRY C.,JR. 06 ACT I
2009 VINEVILLE AVE., MACON 31204
WHITE,PERRY M. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
WHITE,RONALD P. 29 ACT EM
340 BOULEVARD NE, ATLANTA 30312
WHITE,STEPHEN R. 08 A SU
203 DONEHOO ST, BOX 966, STATESBORO 30458
WHITE,WILLIAM H.,JR. 34 ACT OBG
1100 VINE ST. NE, GAINESVILLE 30501
WHITE,WM. P. 22 ACT PD
558 MEDLOCK RD., DECATUR 30030
WHITEHEAD,C. MARK 68 ACT U
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303 SMITH ST., LAGRANGE 30240
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1365 CLIFTON RD. NE, ATLANTA 30322
WHITESIDES,THOMAS E.,JR. 29 ACT OR
EMORY UNIV. CLINIC, ATLANTA 30322
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1221 MEMORIAL DR., DALTON 30720
WHITLOCK,PAUL A.,JR 08 ACT SU
203 DONEHOO ST, BOX 966, STATESBORO 30458
WHITNEY,DOUGLASS G. 29 ACT SU
353 PARKWAY DR. NE, ATLANTA 30312
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1901 N. 2ND CT., LANETT, ALA. 36863
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1000 JOHNSON FERRY RD. NE, ATLANTA 30305
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1276 MCCONNELL DRIVE, DECATUR 30033
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6500 VERNON WOODS DR., ATLANTA 30328
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490 PEACHTREE ST. NE, ATLANTA 30308
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490 PEACHTREE ST. NE, ATLANTA 30308
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792 CHURCH ST. EXT., MARIETTA 30060
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275 FIFTH ST. NW, ATLANTA 30318
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1275 CLEVELAND AVE., EAST POINT 30344
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634 PINE OAK DR., ERIE,PA. 16504
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710 PEACHTREE ST. NE, ATLANTA 30308
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1505 WINTER ST., AUGUSTA 30904
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1624 COLEMAN AVENUE, MACON 31201
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812 13TH ST., AUGUSTA 30901
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BOX 568, DOUGLAS 31533
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4511 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
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1521 POPE AVE., AUGUSTA 30904
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3001 S. COBB DR., SMYRNA 30080
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5297 BRANDYWINE DR., MACON 31204
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3010 HAMPTON AVE., BRUNSWICK 31520
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5105 PAULSEN ST., SAVANNAH 31405
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BOX 367, DEMOREST 30535
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684 CHEROKEE ST., MARIETTA 30060
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41 NELSON ST., CARTERSVILLE 30120
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P. O. BOX 273, LEESBURG 31763
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515 E. 63RD ST., SAVANNAH 31405
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35 COLLIER RD. NW, ATLANTA 30309
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35 COLLIER RD. NW, ATLANTA 30309
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3312 PIEDMONT RD.,NE, ATLANTA 30305
WOMBLE,J. G. 54 ACT SU
1256 MERRY ST., AUGUSTA 30904
WOOD,CLAYTON E. 23 ACT D
1009 N. MONROE, ALBANY 31701

WOOD,D. LLOYD 76 DE5 FP
200 1/2 KING STREET, DALTON 30720
WOOD,HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FORT GAINES 31751
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3764 BRIARCLIFF RD. NE, ATLANTA 30345
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923 CASTLE FALLS DR. NE, ATLANTA 30329
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620 PEACHTREE ST. NE, ATLANTA 30308
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2913 BRANSFORD RD., AUGUSTA 30904
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2017 DESMOND DR., DECATUR 30033
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365 WINN WAY, DECATUR 30030
WYLIE,M. H. 54 ACT SU
1403 GWINNETT ST., AUGUSTA 30902
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861 FOLKS ST., WAYCROSS 31501
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5112 PAULSEN ST.,STE.101, SAVANNAH 31405
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212 HOSPITAL DR., WARNER ROBINS 31093
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3158 MAPLE DR #49, ATLANTA 30305
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150 ROBIN HOOD RD. NE, ATLANTA 30309
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2845 ENGLE RD.,NW, ATLANTA 30318
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P. O. BOX 67, JESUP 31545
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2687 OVERLOOK DR. NE, ATLANTA 30345
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213-B ARROWHEAD BLVD., JONESBORO 30236
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50 COCA COLA PL. SE, ATLANTA 30303
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704 RUNNYMEDE CIR., VA. BCH., VA. 23452
LAU,FOOK S. 02 ACT I
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
MAJANOVIC,MAHMUD 02 ACT PUL
149 RIVERSIDE DR., MILLEDGEVILLE 31061
MARTINEZ,A. C. 02 ACT I
P. O. BOX 677, MILLEDGEVILLE 31062
MCLAREN,JOHN R. 02 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
MENDEZ,SALVADOR A. 02 ACT P
1006 RIVERBEND DR., MILLEDGEVILLE 31061
MOORE,PERRY 02 ACT R
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061
PASCUAL,RAFAEL R. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
PERDOMO,ROBERTO R. 02 ACT FP
STATE HOSP., MILLEDGEVILLE 31061
PEREZ,JUAN 02 ACT
CENTRAL STATE HOSPITAL, MILLEDGEVILLE 31062
PORTILLO,LORENZO A. DEL 02 ACT P
P.O. BOX 507, HARDWICK 31034
RAVELO,HUMBERTO C. 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31061
RAVITA,JOHN S. 02 ACT FP
264 GREEN STREET, MONTICELLO 31064
REGALADO,JACINTO 02 A FP
P.O. BOX 578, HARDWICK 31034
REY,ROBERTO 02 ACT P
CENTRAL STATE HOSP., MILLEDGEVILLE 31062
SCOTT,WILBUR M. 02 ACT SU
230 JEFFERSON ST., MILLEDGEVILLE 31061
SMITH,W. T. 02 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062
SOMMERVILLE,MARGARET J. 02 ACT FP
90 W. WIEUCA RD. NE, ATLANTA 30342
STINCER,ELPIDIO F. 02 ACT P
STATE HOSP., MILLEDGEVILLE 31061
TAMAYO,PEDRO L. 02 ACT OR
BOX 714, MILLEDGEVILLE 31061
VALDECANAS, VIRGILIO 02 ACT SU
P.O. BOX 1151, MILLEDGEVILLE 31061
VEAL,CURTIS F. 02 ACT FP
P.O. BOX 489, MILLEDGEVILLE 31061
WORD,J. J. 02 ACT P
STATE HOSPITAL, MILLEDGEVILLE 31062

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DICKENS,WINBURN J. 03 ACT FP
802 EAST AVE., WINDER 30680
ETHERIDGE,E. H. 03 ACT FP
WINDER 30680
HODGES,HUGH O. 03 ACT FP
703 E. BROAD ST., WINDER 30680
HOUSE,JOHN C. 03 ACT FP
703 E. BROAD ST., WINDER 30680
RANDOLPH,W. QUENTON 03 ACT FP
WINDER 30680
RANDOLPH,W. T. 03 DE5 FP
716 3RD AVE.,, WINDER 30680
RICE,GUY V. 03 R PH
3116 RANDOLPH RD. NE, ATLANTA 30345
SKELTON,C. B. 03 ACT FP
WINDER 30680
SOUTHER,JOE C. 03 ACT FP
802 E. BROAD ST., WINDER 30680

4—BARTOW

BROWN,GROVER J. 04 ACT FP
P. O. BOX 338, LINDALE 30147
DAVIS,LAWRENCE P. 04 ACT SU
P.O. BOX 764, CARTERSVILLE 30120
DILLARD,WILLIAM B.,JR. 04 ACT FP
P. O. BOX 468, CARTERSVILLE 30120
EVANS,DONALD C. 04 ACT FP
NEAMAR VILLAGE, CARTERSVILLE 30120
GRIFFIN,RICHARD A.,III 04 ACT SU
P. O. BOX 764, CARTERSVILLE 30120
HAMILTON,VIRGINIA D. 04 A PH
BOX 1196, ROME 30161
HOWELL,WM. HARVEY 04 ACT
41 NELSON ST., CARTERSVILLE 30120
HUDSON,CARLTON B. 04 ACT R
15 WOODVIEW DR., CARTERSVILLE 30120
OROSZ,JUDY I. 04 ACT PD
19 NELSON ST., CARTERSVILLE 30120
SCHMIDT,RICHARD E. 04 ACT EM
P.O. BOX 1008, CARTERSVILLE 30120
WHATLEY,LEWIS R. 04 DE1 FP
38 GREEN ST., CARTERSVILLE 30120

5—BEN HILL-IRWIN

DURDEN,CHARLES H. 05 ACT FP
P. O. BOX 480, FITZGERALD 31750
JOHNSON,ROY J.,JR. 05 ACT FP
MEDICAL ARTS BLDG., FITZGERALD 31750
MAHAYNI,AHMAD S. 05 ACT SU
P.O. BOX 988, FITZGERALD 31750
MIXON,GEORGE E. 05 ACT FP
BOX 246, OCILLA 31774
ROBERTS,RALPH D. 05 ACT FP
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SAMS,WILLIAM C.,JR. 05 ACT FP
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MEDICAL ARTS BLDG., FITZGERALD 31750

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3037 MALVERN HILL DR., MACON 31208
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235 MEDICAL COURT, FORSYTH 31029
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380 HOSPITAL DRIVE, MACON 31201
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724 HEMLOCK ST., MACON 31201
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724 HEMLOCK ST., MACON 31201
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724 HEMLOCK STREET, MACON 31201
AVANT,EARL S. 06 ACT ANES
2923 GENERAL LEE RD., MACON 31204
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618 ORANGE ST., MACON 31201
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671 HEMLOCK ST., MACON 31201
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744 FIRST ST., MACON 31201
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531 NORTH AVE., MACON 31201
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781 SPRING ST., MACON 31201
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740 HEMLOCK ST., MACON 31201
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800 FIRST ST., MACON 31201
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306 ORANGE ST., MACON 31201
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722 FIRST STREET, MACON 31201
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1640 COLEMAN AVE., MACON 31201
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740 HEMLOCK ST., MACON 31201
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2635 STANISLAUS CIR., MACON 31204
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1383 OGLETHORPE ST., MAON 31201
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380 HOSPITAL DR., MACON 31201
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745 PINE ST., MACON 31201
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4754 OXFORD RD., MACON 31204
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577 WALNUT ST., MACON 31201
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227 ORANGE ST., MACON 31201
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417 AMERICAN FEDERAL BLDG., MACON 31201
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380 HOSPITAL DR.,460, MACON 31201
GRANTHAM,C. G. 06 ACT ANES
P. O. BOX 352, GRAY 31032
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380 HOSPITAL DR., MACON 31201
GRIFFIN,WARREN L.,JR. 06 ACT OTO
800 FIRST ST., MACON 31201
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380 HOSP. DR., MACON 31201
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657 HEMLOCK STREET, MACON 31201
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3834 THE PRADO, MACON 31204
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742 CAPTAIN KELL DR., MACON 31204
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781 SPRING ST., MACON 31201
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765 SPRING ST., MACON 31201
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777 HEMLOCK ST., MACON 31208
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1055 WALNUT ST., MACON 31201
HERRING,JOHN S.,JR. 06 ACT OBG
675 NEW ST., MACON 31201
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1221 NEWBURG AVE., MACON 31206
HOGAN,J. T.,JR. 06 ACT FP
781 SPRING ST., MACON 31201
HOLDEN,WILLIAM H. 06 DE5 ALR
%HS COLBATH, 380 RIVERDALE RD, MACON 31204
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1654 TWIN PINES DR., MACON 31201
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645 FIRST STREET, MACON 31201
HOUSER,FRANK M. 06 ACT FP
781 SPRING ST., MACON 31201
HUGHES,ANDREW J. 06 ACT FP
3741 HOUSTON AVE., MACON 31201
HURST,JAMES B. 06 ACT PATH
BALDWIN COUNTY HOSP., MILLEDGEVILLE 31061
IRELAND,CHARLES R. 06 ACT I
380 HOSPITAL DRIVE, MACON 31201
JACKSON,GORDON W. 06 ACT OBG
380 HOSP. DR., MACON 31201
JAMES,C. W.,JR. 06 ACT FP
3741 HOUSTON AVE., MACON 31206
JAMES,LILLAS L. 06 ACT FP
729 PINE ST., MACON 31201
JARRAT,W. D. 06 ACT OPH
626 FIRST ST., MACON 31201
JOHNS,CHARLES W. 06 ACT FP
3741 HOUSTON AVE., MACON 31206
JOHNSON,CLARENCE E.,JR. 06 ACT SU
870 HIGH STREET, MACON 31201
JOHNSON,MILTON I.,JR. 06 ACT FP
2605 CHEROKEE AVE., MACON 31204
JOHNSTON,G. A. 06 ACT
755 MONROE STREET, MACON 31201
JONES,GEORGE R. 06 ACT OPH
626 FIRST ST., MACON 31201
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GRAY 31032
JONES,JOHN P. 06 ACT PD
885 PINE ST., MACON 31201
JONES,ROBERT H. 06 ACT I
675 NEW ST., MACON 31201
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883 PINE STREET, MACON 31201
JORDAN,WILLIAM K. 06 ACT OBG
675 NEW ST., MACON 31201
KAY,FERDINAND V. 06 ACT FP
1221 NEWBERG AVE., MACON 31206
KEEN,O. F. 06 DE5 SU
AMERICAN FEDERAL BLDG., MACON 31201
KELLY,ELMO C.,III 06 ACT D
700 SPRING ST., MACON 31701
KELLY,GENE M. 06 ACT ANES
148 TEN KNOLLS DR., MACON 31204
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283 BUFORD PL., MACON 31201
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380 HOSP. DR., MACON 31201
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990ST. ANDREWS RD., MACON 31204
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7405 IND. HWY., MACON 31206
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380 HOSP. DR., MACON 31201
LEWIS,WM. EARL 06 ACT SU
280 HOSPITAL DR #430, MACON 31201
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781 SPRING ST., MACON 31201
LONGAKER,PAUL E. 06 ACT FP
4915-G RIVOLI DR., MACON 31204
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800 FIRST ST., MACON 31201
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380 HOSP. DR., MACON 31201
MANN,DAVID S. 06 ACT
645 FIRST STREET, MACON 31201
MARTIN,J. O. 06 ACT OPH
745 PINE ST., MACON 31201
MAURIZI,CHARLES P. 06 ACT PATH
3049 MALVERN HILL DR., MACON 31201
MAYES,ALVA LOUIE,JR. 06 ACT PD
2009 VINEVILLE AVE., MACON 31204
MAYS,J. R. S. 06 DE5 P
700 SPRING ST., MACON 31201
MCALLISTER,ROBERT W. 06 ACT P
N. HOUSTON RD., A-1, WARNER ROBINS 31093
MCCARD,RAY H. 06 ACT P
596 ARLINGTON PL., MACON 31201
MCLENDON,JOE L. 06 ACT OPH
P. O. BOX 956, MACON 31202
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2869 NAPIER AVE., MACON 31204
MCMILLAN,E. C.,JR. 06 ACT SU
670 NEW ST., MACON 31201
MENENDEZ,JACK F. 06 ACT SU
700 SPRING ST., MACON 31201
METTS,BETTY HOGAN 06 ACT ANES
723 CAPTAIN KELL DR., MACON 31204
MITCHELL,ALEX R. 06 ACT PATH
MEDICAL CENTER OF CENTRAL GA., MACON 31208

MOODY,RAYMOND A. 06 ACT FP
755 ORANGE ST., MACON 31201
NEAL,JULE C.,JR. 06 ACT OBG
380 HOSP. DR., MACON 31201
NELSON,HOMER S. 06 ACT OPH
BOX 956, MACON 31202
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608 AMERICAN FEDERAL BLDG., MACON 31201
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4-D MASSEE APTS., MACON 31201
NEWTON,MILLEGE C. 06 ACT I
380 HOSPITAL DR., MACON 31201
NEWTON,RALPH G.,JR. 06 ACT U
718 FIRST ST., MACON 31201
NEWTON,W. R. 06 ACT
801 SPRING ST., MACON 31201
OLNICK,HERBERT M. 06 R R
724 HEMLOCK ST., MACON 31201
ORR,WILLIAM W. 06 ACT PD
2009 VINEVILLE AVE., MACON 31204
OSHAUGHNESSEY,W. JHN JR. 06 ACT I
618 ORANGE ST., MACON 31201
PAGE,JOHN A. 06 ACT OPH
800 FIRST ST., MACON 31201
PENNINGTON,CLAUDE LEE 06 ACT ALR
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856 1ST ST., MACON 31201
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781 SPRINGS ST., MACON 31201
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380 HOSPITAL DR., MACON 31201
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4946 BRITTANY DR., MACON 31204
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670 NEW STREET, MACON 31201
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1860 FLINTWOOD DR., MACON 31201
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752 HEMLOCK ST., MACON 31201
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1107 SOUTHERN TRUST BLDG., MACON 31201
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2934 VICTORIA CIR., MACON 31201
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729 PINE ST., MACON 31201
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3055 GENERAL LEE RD., MACON 31204
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5151 ZEBULON RD., MACON 31204
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RT. 3, BOX 43, FORSYTH 31029
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700 SPRING ST., MACON 31201
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718 FIRST ST., MACON 31201
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P. O. BOX 6000, MACON 31208
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380 HOSPITAL DR., MACON 31201
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376 ROGERS AVE., MACON 31204
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765 SPRING ST., MACON 31201
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1175 PEACHTREE ST. NE, ATLANTA 30361
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784 SPRING ST., MACON 31201
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718 FIRST ST., MACON 31201
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618 ORANGE ST., MACON 31201
SHIRLEY,WM. C. 06 ACT OBG
380 HOSP. DR., MACON 31201
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803 SPRING ST., MACON 31201
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740 HEMLOCK ST., MACON 31201
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STAHL,LOREN C. 06 ACT I
618 ORANGE ST., MACON 31201
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839 1ST ST., MACON 31201
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770 HEMLOCK ST., MACON 31201
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745 PINE ST., MACON 31201
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P. O. BOX 6317, MACON 31208
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700 SPRING STREET, MACON 31201
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2983 VICTORIA DR., MACON 31201
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1142 DRUID PARK AVE., AUGUSTA 30904
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634 PINE OAK DR., ERIE,PA. 16504
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1624 COLEMAN AVENUE, MACON 31201
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781 SPRING ST., MACON 31201
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CLEMONS,THURMAN 08 ACT FP
P. O. BOX 821, STATESBORO 30458
CURRY,LEON E. 08 ACT FP
P. O. BOX 267, METTER 30439
DANIEL,A. B. 08 ACT SU
P. O. BOX 717, STATESBORO 30458
DEAL,ALBERT M. 08 ACT SU
P. O. BOX 647, STATESBORO 30458
DEAL,HELEN R. 08 ACT PD
P. O. BOX 647, STATESBORO 30458
DEAL,JOHN D. 08 ACT FP
P. O. BOX 1043, STATESBORO 30458
GLENN,FRANK D. 08 I&R U
510 GENTILLY ROAD, STATESBORO 30458
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101 E. COLLEGE AVE., MILLEN 30442
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356 NORTHSIDE DR.,E., STATESBORO 30458
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P. O. BOX 1066, STATESBORO 30458
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P. O. BOX 486, STATESBORO 30458
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P. O. BOX 527, STATESBORO 30458
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110 E. COLLEGE AVE., MILLEN 30442
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P. O. BOX 388, METTER 30439
RICHARDSON,CHARLES R. 08 ACT OBG
P. O. BOX 1066, STATESBORO 30458
ROBINSON,ROBERT S. 08 ACT FP
P. O. BOX 45, METTER 30439
SANTIAGO, MARCELO R. 08 ACT SU
P.O. BOX 800 , CLAXTON 30417
SMITH,HERBERT D. 08 ACT P
127 N. MAIN ST., STATESBORO 30458
SMITH,J. DORSEY 08 ACT FP
MEDICAL ASSOC. OF METTER., METTER 30439
STAMBUK,ROBERT B. 08 ACT R
P. O. BOX 1048, STATESBORO 30458
SWINT,ROBERT H. 08 ACT SU
P. O. BOX 1088, STATESBORO 30458
THOMPSON,JOSIAH 08 ACT SU
MCKINLEY & SMITH STS., CLAXTON 30417
TILLMAN,SAMUEL P. 08 ACT I
302 DONEHOO ST., STATESBORO 30458
WHITE,STEPHEN R. 08 A SU
203 DONEHOO ST, BOX 966, STATESBORO 30458
WHITLOCK,PAUL A.,JR 08 ACT SU
203 DONEHOO ST, BOX 966, STATESBORO 30458

9—BURKE

BYNE,J. M.,JR. 09 DE5 I
LIBERTY ST., WAYNESBORO 30830
GREEN,CHARLES G. 09 ACT FP
223 EAST 6TH ST., WAYNESBORO 30830
HENSLEY,E. R. 09 ACT
MEDICAL CENTER OF CENTRAL GA., MACON 31201
MURRAY,B. LAMAR 09 ACT
FOURTH ST., WAYNESBORO 30830
THOMPSON,CLEVELAND,JR. 09 DE1 FP
RT 2 BOX P-47 F, SANTEE, SC 29142
VOYLES,WALTER R. 09 ACT SU
307 FOURTH ST., WAYNESBORO 30830

10—CARROLL-DOUGLAS-HARALSON

ALLEN,R. D. 10 ACT
TALLAPOOSA 30176
ARRENDALE,JOE J. 10 ACT FP
8435 PRICE AVE., DOUGLASVILLE 30134
ASTIN,PHIL C.,JR. 10 ACT FP
702 DIXIE STREET, CARROLLTON 30117
BATCHELOR,CURTIS A. 10 ACT FP
405 ALABAMA ST., BREMEN 30110
BERRY,ROBERT L. 10 ACT FP
VILLA RICA 30180
BOSS,JAMES L. 10 ACT FP
VILLA RICA 30180
COLDITZ,RICHARD B. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
COLIER,HOWARD J. 10 ACT OR
6287 FAIRBURN RD., DOUGLASVILLE 30134
DENNEY,ROY L. 10 ACT OALR
CARROLLTON 30117
DOWNEY,W. P. 10 ACT FP
TALLAPOOSA 30176
GONZALEZ,EVANGELIO 10 ACT FP
611 N. AVENUE, VILLA RICA 30180
GRANT,EDWIN H. 10 ACT R
TANNER MEMORIAL HOSP., CARROLLTON 30117
GREEN,JAMES FRANKLIN 10 ACT FP
POWELL CLINIC, VILLA RICA 30180
GRESHAM,WALTER S. 10 ACT
BOWDEN 30108
HATIPOGLU,V.B. 10 ACT I
819 DIXIE STREET, CARROLLTON 30117
JOHNSON,MARTIN L. 10 ACT
BOWDON 30108
MARTIN,TALMADGE M. 10 ACT SU
619 DIXIE STREET, CARROLLTON 30117
MCLENDON,HAROLD L. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
MCLENDON,JULIAN K. 10 ACT
405 ALABAMA AVENUE, BREMEN 30110
MERRITT,CHARLES R. 10 ACT PD
107 CLINIC AVE., CARROLLTON 30117
PARRISH,JOE E. 10 ACT OBG
115 HOSPITAL DR., CARROLLTON 30117
PATRICK,E. V. 10 ACT I
CARROLLTON 30117
POWELL,JOHN E.,JR. 10 ACT FP
VILLA RICA 30180
PRITCHETT,JOHN H.,JR. 10 ACT
BREMEN 30110
REEVE,THOMAS E.,JR. 10 ACT SU
CARROLLTON 30117

REID,RAYMOND J.,JR. 10 ACT FP
P. O. BOX 325, TALLAPOOSA 30176
ROBINSON,A. CLARK 10 ACT FP
P. O. BOX 1116, DOUGLASVILLE 30134
ROBINSON,J. C. 10 ACT R
TANNER MEM. HOSP., CARROLLTON 30117
SEAGO,RICHARD W. 10 ACT SU
405 ALABAMA AVE., BREMEN 30110
SMITH,WILLIAM P.,JR. 10 ACT SU
BOWDON 30108
STRICKLER,D. T.,JR. 10 ACT FP
P. O. BOX 518, DOUGLASVILLE 30134
TAYLOR,THOMAS B. 10 ACT
DOUGLASVILLE 30134
VANSANT,CLAUDE V.,SR. 10 DE5 FP
DOUGLASVILLE 30134
VANSANT,CLAUDE V.,SR. 10 DE5 FP
P.O. BOX 1195, DOUGLASVILLE 30134
WORTHY,W. STEVE 10 ACT OBG
115 HOSP. DR., CARROLLTON 30117
WRIGHT,J. CARTER 10 ACT SU
624 DIXIE ST., CARROLLTON 30117

11—GEORGIA MEDICAL SOCIETY
(Bryan, Chatham, Effingham, Long, McIntosh)

ALEXANDER,J. L. 11 ACT SU
40 MEDICAL ARTS CENTER, SAVANNAH 31405
ALVAREZ,M. L. 11 ACT PATH
1804 STILLWOOD DR., SAVANNAH 31406
ANGELL,JOHN H. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
APPLETON,BROWN G. 11 ACT EM
P.O. BOX 6688, STA. C, SAVANNAH 31405
ARKIN,MURRAY C. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405
BALL,WESLEY J. 11 ACT SU
1814 ABERCORN ST., SAVANNAH 31401
BARGERON,EUGENE P. 11 ACT OR
P.O. BOX 6156, SAVANNAH 31405
BEDINGFIELD,W. O. 11 DE5
3025 BULL ST., SAVANNAH 31405
BEESON,CHARLES W.,II 11 ACT C
803 E. 70TH ST., #103, SAVANNAH 31405
BERENS,SANFORD V. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405
BERLIN,MELVIN 11 ACT
1 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
BODZINER,L. S. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
BOUSQUET,FRANKLYN P.,JR 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31402
BOWDEN,RALPH O. 11 ACT
22 E. TAYLOR ST., SAVANNAH 31401
BRADBURY,ROBERT G. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
BRANDT,HENRY A. 11 ACT PN
220 EAST HALL STREET, SAVANNAH 31401
BRAWNER,D. L. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
BRENNAN,CARL H. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
BRODERICK,JOHN R. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
BROWN,ALAN P. 11 ACT EM
P. O. BOX 13312, SAVANNAH 31406
BROWN,CHARLES T. 11 DE5 PH
BOX 7, GUYTON 31312
BUCKHAULTS,W. W. 11 ACT OPH
905 ABERCORN STREET, SAVANNAH 31401
BUELVAS,RAUL S. 11 ACT SU
11706 MERCY BLVD., SAVANNAH 31406
BURGSTINER,CARSON B. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
CANNON,CLIFTON L.,JR. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405
CAPLAN,GERALD E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
CARLTON,FRANK E. 11 ACT U
P.O. BOX 3458, SAVANNAH 31403
CARSON,GORDON C.,III 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
CARTER,ROBERT H. 11 ACT SU
1020 DRAYTON ST., SAVANNAH 31401
CENTER,A. H. 11 ACT PN
10 MEDICAL ARTS CENTER, SAVANNAH 31405
CHENG,YUNG-SHENG 11 ACT OBG
8508 KENT DR., SAVANNAH 31406
CIRINCIONE,V. J. 11 ACT D
46 MEDICAL ARTS CENTER, SAVANNAH 31405
CLARKE,GEORGE D. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
CLARY,W. UPTON 11 ACT NS
22 MEDICAL ARTS CENTER, SAVANNAH 31405
CLAYTON,MAX L. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
COBB,ELLIOTT A. 11 ACT
P.O. BOX 6688, STA. C, SAVANNAH 31405
COLMERS,RUDOLF A. 11 ACT I
217 E HUNTINGDON ST., SAVANNAH 31401
COSTA,CONRADO V.,JR. 11 ACT FP
P. O. BOX 9787, SAVANNAH 31402
CRYMES,JOHN M. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAV 31405
DAILY,F. WILLSON 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
DANZIG,LAMONT EARL 11 ACT I
P. O. BOX 5086, SAVANNAH 31403
DE REAMER,JOHN W. 11 DE1 D
2917 WEYMAN ST #20, SHREVEPORT, LA. 71104
DEKLE,JOHN L.,JR. 11 ACT OBG
P. O. BOX 5143, SAVANNAH 31403
DEL RIO,GABRIEL G. 11 ACT PD
P. O. BOX 6688, SAVANNAH 31405
DELANCY,HERMAN 11 ACT SU
5102 PAULSEN ST., SAVANNAH 31405
DELOACH,ERVIN D. 11 I&R SU
BOX 6688, STA C, SAVANNAH 31405
DERISO,H. CLARK 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405
DI BENEDETTO,ROBERT J. 11 ACT I
P. O. BOX 5086, SAVANNAH 31405
DIMOND,KEITH A. 11 ACT NE
P. O. BOX 5086, SAVANNAH 31405
DOOLAN,JOHN J.,JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
DOWNING,EDWARD F. 11 ACT NS
22 MEDICAL ARTS CTR., SAVANNAH 31405
DUNCAN,J. HARRY 11 ACT OPH
3025 BULL ST., SAVANNAH 31405
DUNN,LAURENCE B. 11 DE5 FP
P. O. BOX 205, BLUFFTON, S. C. 29910
DYNIN,MICHAELA 11 ACT P
P. O. BOX 13607, SAVANNAH 31406
EDWARDS,A. JOSEPH,JR. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
EDWARDS,ERNEST G.,JR. 11 ACT OR
44 MEDICAL ARTS CENTER, SAVANNAH 31405
ELLIOTT,J. L. 11 DE5 I
212 E. HUNTINGDON ST., SAVANNAH 31401
ERMUTLU,ILHAN M. 11 ACT P
P. O. BOX 119, COLUMBIA, SC 29202
EVANS,JAMES P. 11 ACT PD
5102 PAULSEN ST., #3, SAVANNAH 31405
FAGIN,RONALD R. 11 ACT I
5102 PAULSEN ST., SAVANNAH 31405
FILLINGIM,DAVID B. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401
FILLINGIM,DAVID W. 11 ACT OBG
1 ST. JOSEPH PROF. PLAZA, SAVANNAH 31406
FILLINGIM,JOHN M. 11 ACT FP
449 ABERCORN ST., SAVANNAH 31401
FILSON,EDGAR J. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
FINGER,ELLIOTT R. 11 ACT PL
38 MEDICAL ARTS CENTER, SAVANNAH 31405
FREEDMAN,L. M. 11 ACT SU
803 EAST 70TH ST #105, SAVANNAH 31405

FREEMAN,THOMAS R. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401
FULMER,WM. HENRY 11 ACT FP
22 E. 34TH ST., SAVANNAH 31401
GERMAN,THOMAS L. 11 ACT OR
210 HALL ST. EAST, SAVANNAH 31401
GOLDENSTAR,G. W. 11 ACT OPH
26 MEDICAL ARTS CENTER, SAVANNAH 31405
GONGAWARE,ROBERT D. 11 ACT SU
200 E. 31ST ST., SAVANNAH 31401
GONGAWARE,THEODORA L. 11 ACT I
P.O. BOX 6688, STA. C, SAVANNAH 31405
GOODWIN,BURTON D.,JR. 11 ACT R
P. O. BOX 6688, SAVANNAH 31401
GOTTSCHALK,ROBERT BRUCE 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31401
GRANT,ROBERT W. 11 I&R I
BOX 6688, STA C, SAVANNAH 31405
GUERRY,RODERICK L. 11 ACT PATH
BOX 9787, SAVANNAH 31402
GURSEL,SEZAI 11 ACT PATH
P.O. BOX 9787, SAVANNAH 31402
GUZZARDI,LAWRENCE J. 11 ACT EM
11705 MERCY BLVD., SAVANNAH 31406
HABERMAN,GEORGE G. 11 ACT SU
P. O. BOX 9787, SAVANNAH 31402
HADAWAY,PHIL L. 11 ACT FP
716 E. 71ST ST., SAVANNAH 31405
HADDAD,LESTER M. 11 ACT EM
P.O. BOX 6688, STA. C, SAVANNAH 31405
HAHN,EDWARD E. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406
HAM,OSCAR EMERSON 11 ACT PD
835 E. 65TH ST., SAVANNAH 31405
HARDEMAN,FRANK 11 ACT EM
DE RENNE APTS., SAVANNAH 31401
HARRIS,JOHN A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
HARTMANN,HARRY R. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
HEFFERNAN,J. ANTHONY,JR 11 ACT FP
20 MEDICAL ARTS CENTER, SAVANNAH 31405
HETHERINGTON,THOMAS A. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
HOFFMAN,FRANK 11 ACT ALR
24 MEDICAL ARTS CENTER, SAVANNAH 31405
HOLLOMAN,J. J. 11 ACT FP
313 E. HALL STREET, SAVANNAH 31401
HOOD,E. D. 11 ACT FP
241 ABERCORN ST., SAVANNAH 31401
HOWARD,JOHN C. 11 ACT OALR
317 E. HALL STREET, SAVANNAH 31401
HOWARD,LEE,JR. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403
HOWARD,ROBERT M. 11 DE1 PATH
622 E. 44TH ST., SAVANNAH 31406
HUTCHESON,MORRIS W. 11 ACT PD
5102 PAULSEN ST., SAVANNAH 31406
JACKSON,JAMES W. 11 ACT SU
1 MED. ARTS CENTER, SAVANNAH 31405
JENNINGS,JANE B. 11 ACT PATH
P. O. BOX 6688, SAVANNAH 31404
JOHNSON,G. HUGO,JR. 11 DE5
116 E. OGLETHORPE AVE., SAVANNAH 31401
JOHNSTON,FRANK M. 11 ACT PN
5105 PAULSEN ST.,STE 140, SAVANNAH 31405
JORDAN,CARL R. 11 ACT SU
P.O. BOX 3567, STA. B, SAVANNAH 31404
JUDY,JAMES C. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
JURGENSEN,PAUL F. 11 ACT I
P. O. BOX 5086, SAVANNAH 31403
KANTER,W. W. 11 ACT
346 BULL ST., SAVANNAH 31402
KELLY,JULIAN D.,JR. 11 ACT OR
600 E. 65TH ST., SAVANNAH 31405
KELLY,WILLIAM D. 11 ACT PATH
ST. JOSEPHS HOSP., SAVANNAH 31406
KESSLER,FRED OTTO,JR. 11 ACT FP
3802 WATERS AVE., SAVANNAH 31404
KING,RUSKIN 11 DE5 PD
10 W. TAYLOR ST., SAVANNAH 31401
KUGLER,MORRIS A. 11 ACT SU
1 MEDICAL ARTS CENTER, SAVANNAH 31405
KURZBACH,ELMER 11 ACT FP
314 E. GASTON ST., SAVANNAH 31401
LANGE,STEPHEN J. 11 ACT FP
509 LEE BLVD., SAVANNAH 31405
LANGE,STEPHEN J.,JR. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
LANIER,LONNIE R.,JR. 11 ACT OBG
2 MEDICAL ARTS CENTER, SAVANNAH 31405
LEBOS,HARVEY C. 11 ACT I
600 E. 70TH ST., SAVANNAH 31406
LEE,JAMES MOULTRIE 11 ACT SU
200 E. 31ST. ST., SAVANNAH 31401
LEE,LAWRENCE,JR. 11 ACT I
2203 ABERCORN STREET, SAVANNAH 31401
LIPPITT,WILLIAM H. 11 ACT SU
200 EAST 31ST STREET, SAVANNAH 31401
LOGAN,JAMES R. 11 ACT OTO
2203 ABERCORN ST., SAVANNAH 31401
LONG,ROBERT F. 11 ACT R
P.O. BOX 6688, STA. C, SAVANNAH 31405
LONG,W. V. 11 DE5 SU
540 E. 49TH STREET, SAVANNAH 31405
LOTT,OSCAR H. 11 DE1 FP
RFD RT. 2, DOUGLAS 31533
LYNCH,LAWRENCE J.,JR. 11 ACT SU
5002 PAULSEN ST.,BLDG. F, SAVANNAH 31405
MANER,FREDERICK DEBELE 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
MARISCANO,ANTHONY R. 11 ACT FP
602 E. 67TH ST., SAVANNAH 31405
MARTENSON,EDGAR 11 ACT FP
42 MEDICAL ARTS, SAVANNAH 31405
MAZO,MILTON 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
MCCULLOUGH,RICHARD E. 11 I&R I
712 EAST 18TH ST, TIFTON 31794
MCDEW,STEPHEN M. 11 ACT OBG
918 W. BROAD ST., SAVANNAH 31401
MCGEE,HARRY H.,JR. 11 ACT R
311 E. HALL ST., SAVANNAH 31401
MCGOLDRICK,THOMAS A.,JR 11 ACT I
15 E. GORDON ST., SAVANNAH 31401
MCREYNOLDS,B. A. 11 ACT SU
224 E. 46TH ST., SAVANNAH 31405
METTS,JAMES C. 11 DE5 I
110 W. GASTON ST., SAVANNAH 31401
METTS,JAMES C.,JR. 11 ACT I
110 W. GASTON ST., SAVANNAH 31401
MILLER,WILLIAM A. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
MOORE,RICHARD W. 11 ACT FP
905 MONTGOMERY ST., SAVANNAH 31401
MOORMAN,CLAUDE T.,II 11 ACT ANES
P.O. BOX 1331, SAVANNAH 31402
MORELAND,ROBERT H.,JR. 11 ACT FP
709 BONNYRIDGE RD, PT. WENTWORTH 31407
MORGAN,HARVEY V. 11 ACT FP
1805 ABERCORN ST., SAVANNAH 31401
MORRISON,CHARLES W. 11 ACT PL
11 MEDICAL ARTS CTR., SAVANNAH 31405
MORRISON,JOSEPH V.,JR. 11 ACT PD
4 MEDICAL ARTS CTR., SAVANNAH 31405
MULHERIN,JOSEPH A. 11 ACT ANES
711 E. 44TH ST., SAVANNAH 31405
MURPHY,HARVEY J. 11 ACT SU
702 E. 66TH ST., SAVANNAH 31405
NASH,D. A. 11 ACT FP
5720 COLONIAL DR., SAVANNAH 31406
NETTLES,JOE L. 11 ACT OR
P. O. BOX 6156, SAVANNAH 31405
NEVILLE, R L 11 DE5 SU
2115 BULL STREET, SAVANNAH 31401
NICHOLS,FENWICK T.,JR. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405
NORTHUP,JOHN D. 11 ACT GE
5705 PAULSEN ST., #125, SAVANNAH 31405

ODOM,LAWRENCE D. 11 I&R
BOX 688 STA C, SAVANNAH 31405
OLIVER,ROBERT LEE 11 DE5 SU
DE RENNE APTS., SAVANNAH 31401
OLSON,CLYDE L. 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31406
ORTIZ,JESUS 11 ACT P
5105 PAULSEN ST., SAVANNAH 31405
OSBORNE,E. S. 11 DE5 OALR
P.O. BOX 870, SAVANNAH BEACH 31328
OSBORNE,W. W. 11 ACT OBG
118 E. 35TH ST., SAVANNAH 31401
OSTEEN,CLARK L. 11 ACT ANES
206 W. BAY ST., SAVANNAH 31401
PACIFICI,JOSEPH 11 ACT FP
2 E. TAYLOR ST., SAVANNAH 31401
PASTORIUS,GEORGE J. 11 DE1 ANES
3601 BULL ST., SAVANNAH 31405
PETERSON,T. A. 11 ACT FP
P.O. BOX 130, AILEY 31410
PHILLIPS,ANDRO P. 11 ACT FP
323 EAST JONES STREET, SAVANNAH 31401
PIATT,EDWARD D. 11 ACT R
9 MEDICAL ARTS CTR., SAVANNAH 31405
PIKE,BENJAMIN L. 11 ACT I
32 MEDICAL ARTS CENTER, SAVANNAH 31405
PORTER,JOHN E. 11 ACT FP
5105 PAULSEN ST., SAVANNAH 31405
PORTMAN,H. J. 11 ACT PD
118 E. 34TH ST., SAVANNAH 31401
POWERS,LEANDER K. 11 ACT FP
29 E. JONES ST., SAVANNAH 31401
PRITZKER,MARTIN S. 11 ACT D
P. O. BOX 13603, SAVANNAH 31406
QUATTLEBAUM,J. K. 11 DE5 SU
3701 WATERS AVE., SAVANNAH 31401
QUATTLEBAUM,J. K.,JR. 11 ACT SU
P.O. BOX 9787, SAVANNAH 31404
QUATTLEBAUM,ROBERT,JR. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403
RABUN,J. B. 11 ACT R
311 E. HALL STREET, SAVANNAH 31401
RAMSEY,SPEIR N. 11 ACT OBG
19 MED. ARTS CENTER, SAV. 31405
RAWSON,CLARENCE W.,JR. 11 ACT OR
P. O. BOX 6156, SAVANNAH 31405
RAZURI,RAFAEL G. 11 ACT SU
1020 DRAYTON ST., SAVANNAH 31401
REEVES,J. LANE 11 ACT OPH
P.O. BOX 13919, SAVANNAH 31406
RHANGOS,WILLIAM C. 11 ACT OR
210 E. HALL ST., SAVANNAH 31401
ROBERTSON,MASON G. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406
ROBINSON,DAVID 11 A R
P.O. BOX 876, SAVANNAH BEACH 31328
ROLLINGS,HARRY E. 11 ACT I
100 E. PARK AVE., SAVANNAH 31401
ROQUE,R. T. 11 ACT FP
SPRINGFIELD MED. PROF., SPRINGFIELD 31329
ROSE,DANIEL W. 11 ACT OTO
17 MEDICAL ARTS CENTER, SAVANNAH 31405
ROSEN,E. F. 11 ACT OALR
5 E. GORDON STREET, SAVANNAH 31401
ROSEN,SAMUEL F. 11 DE5 D
P.O. BOX 960, SAVANNAH BCH. 31328
ROSENGART,CARL L. 11 ACT N
P.O. BOX 6683, SAVANNAH 31405
ROSSITER,FRANCIS P.,JR. 11 ACT AL
5 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
RUSSELL,ALEX P. 11 ACT PATH
MEMORIAL MEDICAL HOSP., SAV. 31405
SAFER,IRWIN H. 11 ACT P
515 E. 63 ST., SAVANNAH 31405
SALTER,W. L. 11 DE1 FP
8915-A OLD MONTGOMERY RD., SAV. 31406
SAX,CHARLES E. 11 ACT OBG
120 E. 34TH STREET, SAVANNAH 31401
SCARBROUGH,ROGER W.,JR. 11 ACT OBG
11706 MERCY BLVD., SAVANNAH 31406
SCARDINO,PETER L. 11 ACT U
P. O. BOX 3458, SAVANNAH 31403
SCHLEY,RICHARD L.,JR. 11 ACT PD
5509 PAULSEN ST., SAVANNAH 31405
SCHNEIDER,M.M. 11 ACT OBG
19 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHNUCK,LLOYD B. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
SCHULZE,RICHARD R. 11 ACT OPH
728 E. 67TH ST., SAVANNAH 31405
SHARPLEY,JOHN G. 11 ACT SU
1903 ABERCORN ST., SAVANNAH 31401
SHEALY,FRED G. 11 A SU
MEMORIAL MEDICAL CENTER, SAVANNAH 31405
SHEILS,ANDREW T.,JR. 11 ACT OR
#7 ST. JOSEPHS PROF. PLAZA, SAVANNAH 31406
SHEPHERD,EDWIN C. 11 ACT PD
4 MEDICAL ARTS CENTER, SAVANNAH 31405
SHERMAN,ELOISE B. 11 ACT PATH
P.O. BOX 6542, STA. C, SAVANNAH 31405
SIMS,JAMES A. 11 ACT ANES
36 MEDICAL ARTS CTR., SAVANNAH 31405
SISSON,WILLIAM H. 11 ACT P
BOX 6688 STA C, SAVANNAH 31405
SKELTON,MARVIN E. 11 ACT R
5223 PAULSEN ST., SAVANNAH 31405
SMITH,CARL A. 11 ACT ANES
35 LINDEN AVE., ATLANTA 30308
SMITH,H. M. 11 ACT FP
3 MEDICAL ARTS CENTER, SAVANNAH 31405
SMITH,JAMES D. 11 I&R OBG
BO 6688 STA C, SAVANNAH 31405
SOWELL,RAYMOND H.,JR. 11 ACT P
P.O. BOX N, POOLER 31322
SPERIOSU,S. U. 11 ACT P
1202 BRIGHTWOOD DR., SAVANNAH 31405
STONE,R. L. 11 ACT ANES
5737 COLONIAL DRIVE, SAVANNAH 31406
STRAIGHT,GEORGE W. 11 ACT SU
319 E. HALL STREET, SAVANNAH 31401
STREIFF,IRWIN 11 ACT FP
BOX 6688, STA C, SAVANNAH 31405
STUBBS,JOSEPH T.,JR. 11 ACT OPH
720 E. 71ST ST., SAVANNAH 31405
SU,SHAW C. T. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
SUMMERS,ROLAND S. 11 ACT I
P.O. BOX 5086, SAVANNAH 31403
SUTLIVE,WM. G. 11 ACT OBG
120 E. 34TH ST., SAVANNAH 31401
TANNER,DAVID E. 11 ACT R
P. O. BOX 6688, SAVANNAH 31405
TILLINGER,ARNOLD J. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405
TIMMS,DICKY W. 11 ACT SU
9-A MEDICAL ARTS CENTER, SAVANNAH 31405
TORRES,SAMUEL A. 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
TRAIN,JOHN KIRK,JR. 11 ACT ALR
1107 BULL ST., SAVANNAH 31401
USHER,CHARLES JR. 11 ACT NS
6 E. LIBERTY ST., SAVANNAH 31401
VALBUENA,D. A. 11 ACT ANES
36 MEDICAL ARTS CENTER, SAVANNAH 31405
VICTOR,IRVING 11 ACT U
P.O. BOX 6555, SAVANNAH 31405
VICTOR,JULES,JR. 11 ACT I
P. O. BOX 6336, SAVANNAH 31405
WADE,JOHN S. 11 ACT SU
122 E. GASTON ST., SAVANNAH 31401
WALLACE,STUART M. 11 ACT PATH
P. O. BOX 3036, SAVANNAH 31403
WALLER,JAMES T. 11 ACT I
P.O. BOX 6688, STA. C, SAVANNAH 31405
WEBB,RAY D. 11 ACT FP
SPRINGFIELD 31329
WEST,JOHN H. 11 ACT I
P.O. BOX 13626, SAVANNAH 31406
WESTERFIELD,C. W. 11 ACT ANES
801 GOEBEL AVE., SAVANNAH 31404

WHELAN,EDWARD J. 11 ACT U
2113 BULL STREET, SAVANNAH 31401
WHIDDON,C. MAURICE 11 ACT SU
122 E. GASTON ST., SAVANNAH 31404
WILDEY,ROY A. 11 ACT R
9 MEDICAL ARTS CENTER, SAVANNAH 31405
WILKES,LESLIE L. 11 ACT OR
44 MEDICAL ARTS, SAVANNAH 31405
WILLIAMS,A. F. 11 ACT I
423 BULL ST., SAVANNAH 31401
WILLIAMS,C. J. 11 ACT I
P. O. BOX 6167, SAVANNAH 31405
WILLOUGHBY,DAN H. 11 ACT I
2 MIDTOWN MEDICAL CENTER, SAVANNAH 31401
WILLS,BENJAMIN C. 11 ACT PN
835 E. 65TH ST., SAVANNAH 31405
WILSON,ROY G. 11 ACT PL
5105 PAULSEN ST., SAVANNAH 31405
WILSON,W. D. 11 ACT SU
111 E. JONES ST., SAVANNAH 31401
WINBURN,JAMES R.,JR. 11 ACT SU
40 MED. ARTS BLDG., SAVANNAH 31405
WIRTH,FREMONT P. 11 ACT N
22 MEDICAL ARTS CENTER, SAVANNAH 31405
WITHINGTON,JOHN C. 11 ACT I
1801 ABERCORN ST., SAVANNAH 31401
WOLFE,WILLIAM W.,JR. 11 ACT P
515 E. 63RD ST., SAVANNAH 31405
WRIGHT,DONALD A. 11 ACT I
2203 ABERCORN ST., SAVANNAH 31401
WYNN,ROBERT A. 11 ACT SU
5112 PAULSEN ST.,STE.101, SAVANNAH 31405
YEH,JUI-TING THOMAS 11 ACT TS
5112 PAULSEN ST., SAVANNAH 31405
YOUNG,ZELLNER C. 11 ACT FP
28 MEDICAL ARTS CENTER, SAVANNAH 31405
ZIRKLE,JOHN G. 11 ACT SU
14 MEDICAL ART CENTER, SAVANNAH 31405

12—ELBERT

ARNOLD,MCALPIN H. 12 ACT FP
46 LAUREL DR., ELBERTON 30635
CAMPBELL,HAROLD EUGENE 12 ACT FP
46 LAUREL AVENUE, ELBERTON 30635
HANKS,JACK B. 12 ACT FP
33 CHESTNUT STREET, ELBERTON 30635
JOHNSON,A. S.,JR. 12 ACT FP
LAUREL DR., ELBERTON 30635
JOHNSON,A. S.,SR. 12 DE5 OALR
46 LAUREL DR., ELBERTON 30635
MICKEL,CAREY A.,JR. 12 ACT SU
35-7 CHESTNUT ST., ELBERTON 30635
ONEAL,JOHN B.,III 12 ACT SU
33 CHESTNUT ST., ELBERTON 30635
ONEAL,PHYLLIS J. 12 ACT I
33 CHESTNUT ST., ELBERTON 30635

13—CHATTAHOOCHEE
(Forsyth, Gwinnett)

BAGHERI,M.T. 13 ACT TS
14 GWINNETT DR., LAWRENCEVILLE 30245
BOTTOMS,WM. R. 13 ACT FP
601 US HWY 19N, CUMMING 30130
BRAMBLETT,RUPERT H. 13 ACT FP
326 DAHLONEGA RD., CUMMING 30130
CHANG,LUNG-HSIUNG 13 ACT OPH
1300 W. PIKE PL., LAWRENCEVILLE 30245
DOVE,DONALD V. 13 ACT FP
44 S. CLAYTON ST., LAWRENCEVILLE 30245
DUNN,WM. R. 13 ACT
P. O. BOX 668, CUMMING 30130
EZZARD,GEORGE P. 13 ACT FP
CROGAN ST., LAWRENCEVILLE 30245
HAMILTON,THOMAS E. 13 ACT FP
1106 DULUTH HWY,. NW, LAWRENCEVILLE 30245
HARRIS,STERLING A. 13 ACT
DOCTORS BUILDING, BUFORD 30518
HLEAP,DAVID 13 ACT FP
DOCTORS BLDG., CUMMING 30130
HUNT,JAMES 13 ACT FP
P. O. BOX 398, DULUTH 30136
KELLEY, D.C. 13 DE5 FP
370 KROGAN ST NW, LAWRENCEVILLE 30245
KELLEY,D. C. 13 DE5 FP
435 PERRY ST. SW, LAWRENCEVILLE 30245
KENNEDY,T. EUGENE 13 ACT FP
P.O. BOX 358, BUFORD 30518
MARTIN,DAN ALLEN 13 ACT SU
P. O. BOX 347, LAWRENCEVILLE 30245
MARTIN,ELISABETH 13 ACT OBG
P. O. BOX 946, CUMMING 30130
MASHBURN,JAMES S. 13 ACT SU
P. O. BOX 668, CUMMING 30130
MASHBURN,MARCUS 13 DE5 FP
P. O. BOX 668, CUMMING 30130
MASHBURN,MARCUS,JR. 13 ACT OBG
P. O. BOX 668, CUMMING 30130
MASON,M. H. 13 ACT FP
P.O. BOX 248, DULUTH 30136
MAULDIN,JOHN W. 13 ACT FP
1081 29 HWY. S., LAWRENCEVILLE 30245
MILLER,CECIL L. 13 ACT
BUFORD MEDICAL CLINIC, BUFORD 30518
MYERS,ALBERT A. 13 ACT FP
51 S. PTREE ST., NORCROSS 30771
PARRISH,WILLIAM C. 13 ACT FP
160 N. MAIN ST., ALPHARETTA 30201
SIMS,FAYETTE A.,JR. 13 ACT
LAWRENCEVILLE 30245
TEAL,C. B.,JR. 13 DE5 I
HALL CO HLTH DEPT, BOX 1295 GAINESVL 30501
TOOTLE,GEORGE S. 13 ACT SU
P.O. BOX 35, DULUTH 30136
TOOTLE,JERRY C. 13 ACT SU
P.O. BOX 746, DULUTH 30136
WAGES,TOM L. 13 ACT FP
BUFORD MEDICAL CLINIC, BUFORD 30518
WEISMAN,H. JAY 13 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329

14—CHEROKEE-PICKENS

ANDREWS,CHAS. R.,JR. 14 ACT SU
P.O. BOX 308, CANTON 30114
BODDY,A. EVAN 14 ACT
WOODSTOCK 30188
BOSWELL,T. C. 14 ACT FP
TATE 30177
CAUBLE,JOHN A. 14 ACT FP
P. O. BOX 1048, CANTON 30114
COKER,GRADY N. 14 DE5 SU
150 HOSPITAL CIRCLE, CANTON 30114
CUTTS,WILLIAM G.,JR. 14 ACT SU
P. O. BOX 962, CANTON 30114
DARNELL,D.T. 14 ACT FP
TATE 30177
FIELD,DAVID E. 14 ACT FP
MEDICAL LANE, CANTON 30114
FLINT,LUCIEN A. 14 ACT R
R. T. JONES MEM. HOSP., CANTON 30114
GEESLIN,JAMES M. 14 ACT SU
110 WALESKA RD., CANTON 30114
GLAZEBROOK,GEORGE W. 14 ACT SU
110 WALESKA ROAD, CANTON 30114
GOLD,HOMER LECIL,JR. 14 ACT FP
110 WALESKA ST., CANTON 30114
GONZALEZ,FRANCISCO E. 14 ACT OBG
P.O. BOX 311, CANTON 30114
HENDRIX,ARTHUR M. 14 ACT FP
MEDICAL LANE, CANTON 30114

JORDAN,CHARLES G. 14 ACT FP
TATE CLINIC, TATE 30177
LOOPER,BEN KEITH 14 ACT OBG
321 HOSPITAL RD., CANTON 30114
MATHIS,ERNEST H. 14 ACT OBG
P.O. BOX 965, CANTON 30114
NICHOLS,W. H. 14 ACT
110 WALESKA RD., CANTON 30114
PARMER,KEITH M. 14 ACT FP
CANTON MED. CTR., CANTON 30114
PERROW,G. H. 14 ACT FP
JASPER 30143
ROPER,C. J. 14 DE5 SU
JASPER 30143
ROPER,E. A. 14 ACT FP
JASPER 30143

15—CRAWFORD W. LONG
(Clarke, Madison, Oconee, Oglethorpe)

ABNEY,HOWARD T. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
ALLEN,JOHN J. 15 ACT FP
P.O. BOX 6124., ATHENS 30601
BARROW,BEN C. 15 ACT FP
675 RIVERHILL DR., ATHENS 30601
BEALL,JAMES H. 15 ACT P
700 OGLETHORPE AVE., ATHENS 30601
BERGER,ISRAEL REUBEN 15 ACT R
1010 PRINCE AVENUE, ATHENS 30601
BONNER,WILLIAM H. 15 ACT PD
740 PRINCE AVE., ATHENS 30601
BOWEN,WILLIAM L.,JR. 15 ACT OBG
1010 PRINCE AVE., ATHENS 30601
BOYD,AUGUSTUS B. 15 ACT ANES
P. O. BOX 1732, ATHENS 30601
BRANYON,DONALD L.,JR. 15 ACT OBG
1010 PRINCE AVE., ATHENS 30601
BROWN,WALTER J.,JR. 15 ACT I
UNIV HEALTH SERVICE, ATHENS 30602
BURRELL,ZEB,JR. 15 ACT I
ATHENS GENERAL HOSP., ATHENS 30601
CABANISS,W. HARVEY,JR. 15 ACT D
1010 PRINCE AVENUE, ATHENS 30601
CALDWELL,KENDALL W. 15 ACT R

CASKIN,CLINTON R.J.,JR. 15 ACT U
245 WESTVIEW DR., ATHENS 30601
CLARK,NILE R. 15 ACT FP
1160 PRINCE AVE., ATHENS 30601
CLAY,JAMES R. 15 ACT PATH
ATHENS GENERAL HOSPITAL, ATHENS 30601
COHEN, LARRY 15 ACT R
190 BROOMSEDGE TR.,, ATHENS 30601
COHENOUR,JEFFREY H. 15 ACT PATH
BOX 946, MONROE 30655
CREAGH,GERARD B. 15 DE1 PH
555 MILLEDGE CIR., ATHENS 30601
CROSBY,WILLIAM V. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
CURTIS,JOHN R. 15 ACT P
UNIV. HEALTH SERV., ATHENS 30601
DEMPSEY,JAMES E. 15 ACT OTO
1010 PRINCE AVE., ATHENS 30601
DIXON,ELLIS H.,JR. 15 ACT OBG
1010 PRINCE AVENUE, ATHENS 30601
DUBOSE,BOLLING S.,JR. 15 ACT I
225 S. MILLEDGE, ATHENS 30601
ERWIN,GEORGE 15 ACT PD
1010 PRINCE AVENUE, ATHENS 30601
ERWIN,GOODLOE Y. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
FLORENCE,LOREE 15 DE5 PD
P. O. BOX 682, ATHENS 30601
FORD,HENRY J. 15 ACT P
1010 PRINCE AVE., ATHENS 30601
GALLIS,ANTHONY H. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
GARCIA,RUBEN E. 15 ACT FP
1010 PRINCE AVE., ATHENS 30601
GLENN,T. LAMAR 15 ACT I
740 PRINCE AVE., ATHENS 30601
GOMEZ,ROBERT F. 15 ACT OTO
740 PRINCE AVE., ATHENS 30601
GREEN,DONARELL R.,JR. 15 A FP

GREEN,JAMES A. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
GUTIERREZ,RAFAEL 15 ACT P
296 PRINCE AVE., ATHENS 30601
HAMILTON,SANDRA D. 15 ACT ANES
165 DUNWOODY DR., ATHENS 30601
HANNAH,JAMES F. 15 ACT EM
435 PONDEROSA DR., ATHENS 30601
HARDMAN,WILLIAM J. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
HASTON,HUGH B.,JR. 15 ACT OR
125 KING AVE., ATHENS 30601
HERRIN,E. V. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
HILL,JOHN B. 15 ACT OBG
740 PRINCE AVENUE, ATHENS 30601
HINTON,GOLDEN S. 15 ACT OPH
957 BAXTER ST., ATHENS 30601
HOLBROOK,WM. H.,JR 15 ACT R
797 COBB ST., ATHENS 30601
HOLMES,WILLIAM C. 15 DE2 FP
740 PRINCE AVENUE, ATHENS 30601
HUBERT,M. A. 15 DE5 U
466 HIGHLAND AVE., ATHENS 30601
HUNNICUT,J. A. 15 DE5 FP
1070 S. MILLEDGE, ATHENS 30601
JARRELL,ROBERT J. 15 ACT R
ATHENS GENERAL HOSP., ATHENS 30601
JOHNSON,NORMAN,JR. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
KANTSIPER,ALAN B. 15 ACT R
1230 BAXTER STREET, ATHENS 30601
KELLER,A. PAUL,JR. 15 ACT OALR
1010 PRINCE AVE., ATHENS 30601
KELLEY,ROBERT E.,JR. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
KIAS,THOMAS N.,JR 15 ACT I
1010 PRINCE AVENUE, ATHENS 30601
KING,STEPHEN H. 15 S I
PO BOX 8043, ATHENS 30601
KITCHENS,WM. C. 15 ACT I
740 PRINCE AVE., ATHENS 30601
KWON,OH BONG 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
LEWIS,EDWARD L.,JR. 15 ACT D
1077 BAXTER ST., ATHENS 30601
MAXWELL,JAMES W. 15 ACT PD
1010 PRINCE AVE., ATHENS 30601
MCDONALD,J. J. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
MCELHANNON,F. M. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
MCPHERSON,JOHN H. T. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
MONTGOMERY,THOMAS A. 15 ACT SU
1010 PRINCE AVE., ATHENS 30601
MULHERIN,WILLIAM B. 15 ACT OR
125 KING AVE., ATHENS 30601
MUSE,A. D.,JR. 15 ACT SU
740 PRINCE AVE., ATHENS 30601
NEIGHBORS,J. B.,JR. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
NEUFELD,JOCELYN R. 15 ACT ANES
135 GATEWOOD PL., ATHENS 30601
NIX,DILLARD L. 15 ACT OALR
1010 PRINCE AVENUE, ATHENS 30601
PALMER,JACK R. 15 ACT
1010 PRINCE AVE. #E, ATHENS 30601
PAYNE,ROBERT A. 15 ACT U
195 KING AVE., ATHENS 30601
RANDOLPH,R. H. 15 ACT SU
740 PRINCE AVE., ATHENS 30601

READ,SILAS C.,JR. 15 ACT OPH
957 BAXTER ST., ATHENS 30601
ROSE,CORDT E. 15 ACT ANES
110 CHINQUAPIN WAY, ATHENS 30601
SANFORD,SHELTON P. 15 A I

SHEFFIELD,PHILIP 15 ACT
1010 PRINCE AVE., ATHENS 30601
SHIFLET,ROBERT E. 15 ACT U
1010 PRINCE AVE., ATHENS 30601
SMITH,REUBEN J. 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
STEGEMAN,JOHN F. 15 ACT I
1010 PRINCE AVE., ATHENS 30601
SWINGLE,ROGER L. 15 ACT OR
125 KING AVE., ATHENS 30601
TALMADGE,HARRY E. 15 ACT SU
489 N. MILLEDGE AVE., ATHENS 30601
THOMASSON,GEORGE O. 15 ACT CH
P. O. BOX 8043, ATHENS 30601
THOMPSON,JAMES W. 15 ACT I
220 N. MILLEDGE AVENUE, ATHENS 30601
THOMPSON,RAMON C. 15 ACT U
225 S. MILLEDGE, ATHENS 30601
TILLMAN,BILLUPS P. 15 ACT OR
125 KING AVE., ATHENS 30601
TRAYLOR,JAMES BOTHWELL 15 ACT OBG
740 PRINCE AVE., ATHENS 30601
TRICE,JOHN C. 15 ACT P
150 TALMADGE DR., ATHENS 30601
TSAO,SHU-YUN T. 15 ACT PD
698 S. MILLEDGE AVE., ATHENS 30601
TUMLIN,WILLIAM D. 15 ACT FP
LEXINGTON 30648
UTLEY,HENRY G. 15 ACT OPH
759 COBB ST., ATHENS 30601
VANDERBURGH,ALEXANDER 15 A FP
517 HAMPTON CT., ATHENS 30602
WILKINS,JOHN M. 15 ACT ANES
1077 BAXTER ST., ATHENS 30601

16—CLAYTON-FAYETTE

ABELLERA,E. Q. 16 ACT SU
5330 WARRINGTON PL., COLLEGE PK 30349
ACHECAR,FRED A. 16 ACT NS
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
ALFERT,HAROLD J. 16 ACT U
2788 BAYARD ST., #103, EAST POINT 30344
ALONSO,KENNETH B. 16 ACT PATH
2921 MARGARET MITCHELL CT NW, ATLANTA 30327
APANAY,MANOLO B. 16 ACT SU
409 ARROWHEAD BLVD., JONESBORO 30236
ARMBRUSTER, KENT F.W. 16 ACT I
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
ARRUE,LUIS R. 16 ACT PD
250 ARROWHEAD BLVD., CT. A, JONESBORO 30236
ASKEW,JAMES L. 16 ACT R
BOX 21, RIVERDALE 30274
BISNO,DAVID C. 16 ACT OPH
114 CLAYTON PROF. BLDG, RIVERDALE 30274
BUSEY,T. J. 16 DE5 FP
FAYETTEVILLE 30214
CASTILLO,REUBEN 16 ACT FP
P. O. BOX 157, JONESBORO 30236
COHEN,LAWRENCE 16 ACT OBG
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
DAVIS,MATTHEW E. 16 ACT OALR
33 S.W. UPPER RVRDALE RD., JONESBORO 30274
DINNERSTEIN,ALLAN J. 16 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236
DRAKE,HENRY C. 16 ACT FP
PEACHTREE CITY 30214
DUNBAR,ERNEST A.,JR. 16 ACT PD
1035 MAIN ST., FOREST PARK 30050
FEINSMITH, LESLIE M. 16 ACT NE
33 SW UPPER RIVERDALE RD, RIVERDALE 30274
FERNANDEZ,ANDRES P. 16 ACT FP
1660 BETHHAVEN RD., RIVERDALE 30274
GARFIELD,HERBERT I. 16 ACT PD
217 ARROWHEAD BLVD., JONESBORO 30236
GOMEZ,MIGUEL R. 16 ACT ANES
409 ARROWHEAD BLVD, BLDG A, JONESBORO 30236
HADLEY,ELIZABETH 16 ACT R
33 UPPER RIVERDALE RD #105, RIVERDALE 30274
HARRISON,CLYDE C.,JR. 16 ACT
1019 ASTOR AVE., FOREST PARK 30050
HARTLEY,S. T. 16 ACT EM
4614 WINTHROP DR., COLLEGE PK. 30337
HENDRY,CHARLES H. 16 ACT P
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
JOHNSON,CHARLES G. 16 ACT FP
409 ARROWHEAD BLVD BLDG B, JONESBORO 30236
KATZ,MYRON M. 16 ACT OBG
259 ARROWHEAD BLVD., JONESBORO 30236
KUMAR,SUSHIL V. 16 ACT FP
1019 ASTOR AVE., FOREST PARK 30050
LEE,JOON NAM 16 ACT I
555 BATTLE CREEK RD,B-6, JONESBORO 30236
LENNON,ROBERT W. 16 ACT OPH
33 SW UPPER RVDLE RD., RIVERDALE 30274
LEYVA,JOSE S. 16 ACT OBG
33 UPPER RIVERDALE RD #214, RIVERDALE 30274
LUKE,B. D. 16 ACT FP
6103 N. MAIN ST., MORROW 30260
MAYS,ALDINE M.,JR. 16 I&R FP
P. O. BOX 598, STOCKBRIDGE 30281
MCCLELLAN,M.M.,JR. 16 ACT PD
1035 MAIN ST., FOREST PARK 30050
MCDAVID,WILLIAM E.,JR. 16 ACT R
P.O. BOX 21, RIVERDALE 30274
MCMURRAY,ARTHUR A. 16 ACT SU
33 SW UPPER RIVERDALE RD., RIVERDALE 30274
MEDINA,LEONARDO H. 16 ACT U
217 ARROWHEAD BLVD., JONESBORO 30236
NAMER,JOSE B. 16 ACT FP
259 ARROWHEAD BLVD., JONESBORO 30236
PODOBNIKAR, MICHAEL F. 16 ACT SU
P.O. BOX 335, STOCKBRIDGE 30281
QUILALA,EMILIANO P. 16 ACT SU
409 ARROWHEAD BLVD BLDG C, JONESBORO 30236
RILEY,WELLS 16 ACT FP
151 WEST MILL, JONESBORO 30236
SAMS,FERROL A.,JR. 16 ACT FP
FAYETTEVILLE 30214
SAMS,HELEN F. 16 ACT
FAYETTEVILLE 30214
SOUZA,RENATO C. 16 ACT EM
274 SENOIA RD., FAIRBURN 30213
STONE,ALBERT LAWRENCE 16 ACT PD
1035 MAIN STREET, FOREST PARK 30050
VIGIL,RAMON A. 16 ACT ANES
409 ARROWHEAD BLVD, BLDG A, JONESBORO 30236
WERNER,JACQUELINE H. 16 ACT PATH
11 S.W. UPPER RVRDALE RD., RVRDALE 30274
YU,ALBERT 16 ACT SU
213-B ARROWHEAD BLVD., JONESBORO 30236
YUSUFJI,F. A. 16 ACT OR
33 UPPER RIVERDALE RD., RIVERDALE 30274
ZAKARIA,MAJED S. 16 ACT SU
33 SW UPPER RIVERDALE RD., RIVERDALE 30274

17—COBB
(Cobb, Paulding)

AGRAZ,RODOLFO R. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
ARANEDA-CASTILLO,E. R. 17 ACT PD
1676 MULKEY RD., AUSTELL 30001
ARIAS,RAMON A. 17 ACT PD
2404 AUSTELL RD., AUSTELL 30001
ATKINS,MARY T. 17 R PD
173 FOREST DR., SMYRNA 30080

BARDACK,RICHARD A. 17 ACT C
50 PLAZA WAY,NE, MARIETTA 30060
BARNETT,J. C.,JR. 17 ACT NS
776 CANTON RD., MARIETTA 30060
BEASLEY,CARROLL 17 ACT
50 PLAZA WAY, MARIETTA 30060
BEECHAM,PAUL E. 17 ACT P
11457 HACKETT RD., ROSWELL 30075
BENSON,EARL B. 17 ACT ANES
254 CHEROKEE STREET, MARIETTA 30061
BENSON,W. H.,JR. 17 ACT I
3188 ATLANTA ST.,S E, SMYRNA 30080
BERMAN,MERRILL 17 ACT R
1676 MULKEY RD,SW, AUSTELL 30001
BETHEA,JAMES S.,III 17 ACT OR
1664 W. WESLEY RD., ATLANTA 30327
BLOODWORTH,RONALD C. 17 ACT P
3188 ATLANTA ST. SE, SMYRNA 30080
BLOOM,WALTER L. 17 ACT
225 NORTH AVE. NW, ATLANTA 30313
BLUMENTHAL,JEROME B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060
BOWER,THOMAS L. R. 17 ACT ANES
705 JUNIPER ST. NE, ATLANTA 30308
BOWLES,F. NORMAN,JR. 17 ACT PATH
3950 AUSTELL RD., AUSTELL 30001
BRALY,SAMUEL U. 17 ACT FP
DALLAS 30132
BROWN,LEONARD 17 ACT D
1416 CHEROKEE STREET, MARIETTA 30062
BURLEIGH,BRUCE D. 17 ACT FP
37 MOORE AVE.,NE, MARIETTA 30062
BURNS,JAMES B. 17 ACT R
737 CHURCH ST., MARIETTA 30061
BUSSEY,J. G. 17 ACT SU
AUSTELL 30001
BUSSEY,JOSEPH G.,JR. 17 ACT SU
5990 LOVE ST., AUSTELL 30001
CAMBLOR,GONZALO 17 ACT PATH
COBB GENERAL HOSP., AUSTELL 30001
CARAS,THOMAS S. 17 ACT I
641 CHURCH ST., MARIETTA 30062
CARROLL,MICHAEL S. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30062
CAUBLE,GEORGE 17 ACT
ACWORTH 30101
CAUSEY,ROBERT S.,JR. 17 ACT PD
122 CHERRY ST., MARIETTA 30062
CLABBY,JAMES W. 17 ACT I
1642 MULKEY RD. SW, AUSTELL 30001
CLARK,F. B. 17 ACT FP
AUSTELL 30001
CLARK,REMER Y.,JR. 17 ACT FP
1422 CHEROKEE ST., MARIETTA 30062
CLONTS,W. T. 17 ACT R
70 TOWER RD., MARIETTA 30061
COCHRAN,E. B. 17 ACT SU
641 CHURCH ST., MARIETTA 30060
COGGINS,ROBERT P. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062
COHEN,JACK H. 17 ACT SU
NAVAL AIR STATION, MARIETTA 30062
COHEN,RICHARD W. 17 ACT OR
1676 MULKEY RD., AUSTELL 30001
COLQUITT,ALFRED O.,III 17 ACT OR
732 CHEROKEE ST., MARIETTA 30060
COLQUITT,ALFRED O.,JR. 17 ACT OBG
1205 ROSWELL ST., MARIETTA 30062
COLQUITT,HUGH S. 17 ACT
615 ROSWELL STREET, MARIETTA 30062
COOPER,JAMES T. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30062
COXWELL,WAYNE L. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
CRARY,ELY J. 17 ACT OPH
4730 AUSTELL RD., AUSTELL 30001
CRAWFORD,GLENN D. 17 ACT R
COBB GENERAL HOSP., AUSTELL 30001
CURIEL,HECTOR J. 17 ACT FP
8530 HOSPITAL DR., DOUGLASVILLE 30134
CURRY,VIRGIL L. 17 ACT U
2404 AUSTELL-MARIETTA RD., AUSTELL 30001
DAVIS,WILKES H.,JR. 17 ACT OPH
653 CHEROKEE ST. NE, MARIETTA 30060
DAVIS,WILLIAM S. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
DE LEMOS,GASTON P. 17 ACT P
3188 ATLANTA ST SE, SMYRNA 30080
DELLINGER,RAY E. 17 ACT SU
3001 S. COBB DR. SE, SMYRNA 30080
DOXEY,CLEM M.,JR. 17 ACT D
114 CHERRY ST #E, MARIETTA 30060
DUBOSE,LIGE MOULTRIE 17 ACT OPH
1205 ROSWELL STREET, MARIETTA 30062
DUNCAN,ROY G. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
EBERSBACH,DAVID 17 ACT OR
2550 WINDY HILL RD, MARIETTA 30060
ESPY, PAUL D. 17 ACT D
114 CHERRY ST., STE. E, MARIETTA 30060
ESPY,GOODMAN B.,III 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
FEINERMAN,LOIS K. 17 ACT D
1680 MULKEY RD., AUSTELL 30001
FEINERMAN,MICHAEL B. 17 ACT PL
1680 MULKEY RD., AUSTELL 30001
FELDMAN, GARY E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
FERRIER,FRANK L. 17 ACT TS
754 CHEROKEE, MARIETTA 30060
FINCH,CHARLES S.,JR. 17 ACT ANES
2550 WINDY HILL RD., MARIETTA 30061
FISHER, GILBERT F.,JR 17 ACT OBG
592 CUPELO DR., MARIETTA 30060
FLANDERS,CHARLES E.,JR. 17 ACT ANES
754 CHEROKEE ST. NE, MARIETTA 30060
FLETCHER,MELVIN R. 17 ACT PD
122 CHERRY ST., MARIETTA 30060
FORTSON,LUTHER G.,JR. 17 ACT I
KENNESTONE HOSP., MARIETTA 30060
FOWLER,R. W.,JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060
GALLOSTRA,JUAN A. 17 ACT I
2751 HAMMONDTON RD #D-8, MARIETTA 30060
GARDNER,JOSEPH M. 17 ACT OBG
2404 AUSTELL MARIETTA RD., AUSTELL 30001
GARRETT,LUKE G.,JR. 17 ACT
AUSTELL 30001
GERSON,GORDON N. 17 ACT OR
1620 MULKEY RD., AUSTELL 30001
GILLETT,BRUCE M. 17 ACT N
50 PLAZA WAY, MARIETTA 30060
GLOVER,DOUGLAS D. 17 ACT OBG
653 CHEROKEE ST. NE, MARIETTA 30060
GLUCKMAN, RICHARD 17 ACT N
1680 MULKEY RD., AUSTELL 30001
GOLDSTEIN,MARTIN I. 17 ACT D
3001 S. COBB DR. SE, SMYRNA 30080
GOROD,HERBERT 17 ACT P
3188 ATLANTA ST.,SE, SMYRNA 30080
GOULD,MARK A. 17 ACT P
3188 ATLANTA ROAD, SMYRNA 30080
GRAHAM,WISTAR L. 17 ACT NS
86 S. COBB DR., MARIETTA 30063
GRANTIER,DAVID R. 17 ACT FP
COBB GENERAL HOSP., AUSTELL 30001
GREEN,RICHARD L. 17 ACT AL
2480 WINDY HILL RD., MARIETTA 30060
HAGOOD,M. M. 17 ACT SU
50 PLAZA WAY, MARIETTA 30060
HAGOOD,MURL F. 17 ACT SU
660 CHEROKEE ST., MARIETTA 30060
HAGOOD,RICHARD M. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
HALL,GEORGE W. 17 ACT R
3950 AUSTELL RD., AUSTELL 30001
HALL,MAXWELL F.,JR. 17 ACT R
70 TOWER RD., MARIETTA 30060
HAMMONDS,RICHARD LEE 17 ACT FP
AUSTELL 30001

HANSON,I. R.,JR. 17 A R
30 COLLIER RD,APT 8, ATLANTA 30309
HARBOUR,JOHN H. 17 ACT I
P. O. BOX 1266, SMYRNA 30080
HARLEY,EUGENE L. 17 ACT I
P.O. BOX 1266, SMYRNA 30080
HARRISON,GEORGE I. 17 ACT ALR
1416 CHEROKEE ST., MARIETTA 30062
HENDERSON,CHARLES T. 17 ACT SU
521 CAMPBELL HILL ST., MARIETTA 30060
HODGES,JOHN M. 17 ACT SU
805 CAMPBELL ST., MARIETTA 30062
HOLLADAY,WM. EDWARD,JR. 17 ACT
787 CAMPBELL HILL ST., MARIETTA 30062
HUTTENBACH,DIRK E. 17 ACT P
627 CHEROKEE ST. NE, MARIETTA 30060
INGLIS,E. P.,JR. 17 ACT
1308 CHURCH STREET, MARIETTA 30062
INSIGNARES,MANUEL S. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
ISRAEL,PHILIP Z. 17 ACT SU
3001 S. COBB DR. SE, SMYRNA 30080
JABLOW,MITCHELL A. 17 ACT FP
2550 WINDY HILL RD, MARIETTA 30062
JACOBSON,ALAN I. 17 ACT PATH
P. O. BOX 665, MABLETON 30059
JENNINGS,C. M. 17 ACT I
641 CHURCH STREET, MARIETTA 30060
KAISER,RICHARD R. 17 ACT PD
3001 S. COBB DR. SE, SMYRNA 30080
KIMMERLING,RICHARD W. 17 ACT SU
2404 AUSTELL RD., AUSTELL 30001
KING,OLIVER W. 17 ACT SU
3001 S. COBB DR., SMYRNA 30080
KIRKPATRICK,JAS L.,JR. 17 A I

KLEBER,RONALD J. 17 ACT P
84 LACY ST., MARIETTA 30060
KLEIMAN,SCOTT G. 17 ACT OR
3910 AUSTELL RD., AUSTELL 30001
KLINGBEIL,ROBERT TAYLOR 17 ACT PM
KENNESTONE HOSP., MARIETTA 30060
KNOX,JOHN D.,JR. 17 ACT OR
1416 CHEROKEE ST., MARIETTA 30062
KUMAR, VEENI S. 17 ACT PATH
1000 ATLANTA WEST BLVD, LITHIA SPGS 30057
KUSHNAR,ROBERT L.,JR. 17 ACT R
3903 SOUTH COBB DR #105, SMYRNA 30080
KYBURZ,BRUCE A. 17 ACT U
1067 LONGWOOD DR.,SW, MARIETTA 30060
LAMBERT,ROBERT Y. 17 ACT SU
2241 LEWIS ST., KENNESAW 30144
LAYNE,WILLIAM T. 17 ACT OBG
1676 MULKEY RD., AUSTELL 30001
LESSLIE,WILLIAM P. 17 ACT I
86 S. COBB DR., MARIETTA 30060
LIGON,WALTER M. 17 ACT OTO
444 FAIRGROUND ST., MARIETTA 30062
LINDSEY,MARK M. 17 ACT FP
155 TRAIL POINT, ATLANTA 30338
LORENZ,MAX P. 17 ACT U
652 CHURCH ST. NE, MARIETTA 30060
LYNOTT,MARJORIE A. 17 ACT FP
277 FAIRGROUND ST., MARIETTA 30062
MAINOR,ROBERT 17 ACT FP
2874 KING ST. SE, SMYRNA 30080
MALCOM, GEORGE E.,JR. 17 ACT EM
3646 OXFORD TR., MARIETTA 30062
MALONE,ELLIS L. 17 ACT I
3910 AUSTELL RD., AUSTELL 30001
MANNING,JAMES HUNT 17 ACT SU
50 PLAZA WAY, MARIETTA 30060
MANUS,RICHARD CHESLEY 17 ACT FP
1668 MULKEY RD., AUSTELL 30001
MARKLE,C. DAVID 17 ACT I
2271 AUSTELL RD., AUSTELL 30001
MATHIS,W. H.,JR. 17 ACT R
KENNESTONE HOSPITAL, MARIETTA 30061
MAY,ROBERT D. 17 ACT U
50 PLAZA WAY, MARIETTA 30060
MAY,STEPHEN C.,JR. 17 ACT FP
SOUTH MAIN STREET, KENNESAW 30144
MCBRIDE,WALTER W. 17 ACT I
52 TOWER RD., MARIETTA 30062
MCCLURE,E. RUTH 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062
MCGUIRE,JAMES E. 17 ACT OBG

MCKINNON,FRANK W. 17 ACT OR
652 CHURCH ST., MARIETTA 30060
MCLEAN,WM. R. 17 ACT PD
74 MEDICAL SQUARE, MARIETTA 30060
MEADERS,HENRY D. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060
MEADOWS,NOAH D.,JR. 17 ACT I
52 TOWER RD., MARIETTA 30060
MIHALOUITS,KARL S. 17 ACT P
3188 ATLANTA ST., SMYRNA 30080
MIMS,GEO. T.,JR. 17 ACT I
787 CAMPBELL HILL ST., MARIETTA 30062
MITCHELL,MARVIN M. 17 ACT OR
3910 AUSTELL RD., AUSTELL 30001
MITCHELL,P. ROBERT 17 ACT OBG
653 CHEROKEE ST. N.E., MARIETTA 30060
MITCHELL,W. C. 17 ACT FP
SMYRNA 30080
MULLINIKS,ROBERT C.,JR. 17 ACT OBG
2404 AUSTELL RD., AUSTELL 30001
MULLINS,SPENCER G. 17 ACT SU
605 CAMPBELL HILL ST., MARIETTA 30062
MURRAY,DARRELL W. 17 ACT FP
355 OLD POWDER SPRINGS RD, MABLETON 30059
MUSARRA,E. A. 17 ACT FP
220 CHURCH ST., MARIETTA 30060
MUSARRA,E.A.,II 17 ACT PL
5419 CAROLINE, HOUSTON, TX 77004
MUSSER,ELLYN Z. 17 ACT PD
2480 WINDY HILL RD,SE,303, MARIETTA 30062
NANCE,DANA W. 17 ACT SU
142 COUNTRY CLUB DR., NEW ORLEANS, LA 70124
NAZLI,MEHMET H. 17 ACT ANES
1676 MULKEY RD., AUSTELL 30001
NEISTADT,ARNOLD 17 ACT SU
2550 WINDY HILL RD., MARIETTA 30062
NICHOLS,EVANS J. 17 ACT OBG
705 CAMPBELL HILL ST., MARIETTA 30060
NUTTALL,ROBERT P. 17 ACT FP
123 GORDON RD., MABLETON 30059
OKUN,PHILIP 17 I&R P

PALMER,FRED L. 17 ACT R
3865 STORY DR., MARIETTA 30060
PALMER,J. GARY,JR. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060
PARHAM,ROBERT E. 17 ACT N
670 CHEROKEE ST. NE, MARIETTA 30060
PARKER,PRENTISS E.,JR. 17 ACT OBG
3903 SOUTH COBB DR #206, SMYRNA 30080
PATTERSON,WM. C. 17 ACT SU
3903 S. COBB DR., #110, SMYRNA 30080
PAUSA,SERGIO G. 17 ACT SU
123 GORDON RD., MABLETON 30059
PAYNE,PAUL J. 17 ACT OR
652 CHURCH ST., MARIETTA 30060
PENA,LEOPOLD I. 17 ACT SU
3812 AUSTELL RD., MARIETTA 30060
PENNINGTON,JOHN A. 17 ACT ANES
3312 BUNKER HILL DR., MARIETTA 30062
PHILLIPS,JOE M.,JR. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
PORTER,HARRY,JR. 17 ACT P
3188 ATLANTA RD. SE, SMYRNA 30080
PRINCE,ALAN D. 17 ACT N
50 PLAZA WAY, MARIETTA 30060
PROCHNICKI,LOUIS J. 17 ACT OBG
3910 AUSTELL RD., AUSTELL 30001
RAGAN,KENNETH D. 17 ACT P
84 LACY ST., MARIETTA 30060
RANDALL,ALFRED H.,JR. 17 ACT I
641 CHURCH ST., MARIETTA 30060

RE,PETER K. 17 ACT N
50 PLAZA WAY, STE.B, MARIETTA 30060
REILLY,ENOS J. 17 ACT OBG
513 CAMPBELL HILL, MARIETTA 30060
REY,CHARLES J.,JR. 17 ACT SU
4399 AUSTELL RD., AUSTELL 30001
ROBERTS,STEWART R.,JR. 17 ACT R
80 BUTLER ST. SE, ATLANTA 30303
ROONEY,DONALD R. 17 ACT R
70 TOWER RD. NW, MARIETTA 30060
ROPER,RONALD P. 17 ACT U
823 CAMPBELL HILL ST, MARIETTA 30060
ROSE,A. MCKOY,JR 17 ACT SU
732 CHEROKEE ST., MARIETTA 30061
ROSEN,RONALD 17 ACT U

SANDBERG,JOHN 17 ACT
KING-WILLIAMS BLDG., SMYRNA 30080
SANDERS,GERALD E. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
SAYE,WILLIAM B. 17 ACT OBG
72 PLAZA WAY, MARIETTA 30060
SCHMIDT,F. K. 17 ACT U
823 CAMPBELL HILL ST., MARIETTA 30060
SESSIONS,ROBERT T. 17 ACT SU
811 CHURCH ST., MARIETTA 30062
SHAPIRO,STANLEY T. 17 ACT OTO
2550 WINDY HILL RD.,#106, MARIETTA 30062
SHERRER,WEBSTER A. 17 ACT PATH
KENNESTONE HOSPITAL, MARIETTA 30061
SIGAL,HOWARD MARVIN 17 ACT PD
3001 S. COBB DR., SMYRNA 30080
SMITH,DARIUS A. 17 ACT FP
MEDICAL BLDG., DALLAS 30132
SMITH,SAMUEL R. 17 ACT ANES
673 STEWART AVE. NW, MARIETTA 30060
SOMERLOT,WARREN A. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
SPROUSE,JAMES H.,JR. 17 ACT ANES
754 CHEROKEE ST., MARIETTA 30060
STALEY,IRVING T. 17 ACT OPH
653 CHEROKEE ST., MARIETTA 30060
STANCIL,MELODY ANN 17 ACT ANES
1805 ROSWELL RD., #3-F, MARIETTA 30060
STAPLETON,GERALD M. 17 ACT OTO
2550 WINDY HILL ROAD, MARIETTA 30060
STARR,DONALD C. 17 ACT R
KENNESTONE HOSP., RADIOLOGY, MARIETTA 30060
STEPHENS,DAN B. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
STEPHENS,ROBERT O. 17 ACT PD
680 CHURCH ST., MARIETTA 30060
STONE,JOHN R. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060
STRICKMAN,BERNARD 17 ACT FP

STURKIE,THOMAS OTIS 17 ACT OR
652 CHURCH ST., MARIETTA 30060
SWIFT,JONATHAN S. 17 ACT OR
1422 CHEROKEE STREET, MARIETTA 30062
TABATABAI,JAFAR 17 ACT PATH
P.O. BOX 665, MABLETON 30059
TANNER,JACK E. 17 ACT OBG
1200 ROSWELL RD., MARIETTA 30060
TAYLOR,ROBERT P. 17 ACT OPH
615 ROSWELL STREET, MARIETTA 30060
TEEM,M. V. B. 17 ACT I
200 CHEROKEE STREET, MARIETTA 30060
TEEM,MARTIN V.,JR. 17 ACT I
200 CHEROKEE ST., MARIETTA 30060
THIBODEAUX,DAVID C. 17 ACT R
70 TOWER RD. NW, MARIETTA 30062
TILIACOS,JOHN N. 17 ACT OR
104 BEVERLY HILLS DR., MARIETTA 30062
TOOLE,JAMES C. 17 ACT OBG
731 SANDTOWN RD., MARIETTA 30060
TOWNSEND,ROBERT M. 17 ACT FP
627 CHEROKEE ST., MARIETTA 30060
TRIPPE,JUDSON R.,JR. 17 ACT PD
1202 CHURCH ST., MARIETTA 30060
UNDERWOOD,CHARLES R. 17 ACT SU
641 CHURCH ST., MARIETTA 30060
URRUTIA,R.V.,JR. 17 ACT OR
1244 STONEVIEW DR., MARIETTA 30062
VANDERPOOL,GERALD E. 17 ACT AL
2480 WINDY HILL ROAD, MARIETTA 30062
VANSANT,T. J.,JR. 17 ACT I
P. O. BOX 1287, MARIETTA 30062
VAUGHAN,EDGAR ALLEN 17 ACT
74 MEDICAL SQUARE, MARIETTA 30060
VILLANUEVA,L. S. 17 ACT P
1676 MULKEY RD., AUSTELL 30001
WAKEFIELD,JOHN R. 17 ACT
2404 MARIETTA RD., AUSTELL 30001
WALLACE,BILL L. 17 ACT FP
2480 WINDY HILL RD., MARIETTA 30060
WARD,M. CAROLYN 17 ACT OBG
805 CAMPBELL HILL ST., MARIETTA 30062
WARD,MARY C. 17 ACT PD
652 CHURCH ST., MARIETTA 30060
WARNER,JOHN C.,JR. 17 ACT PD
3001 S. COBB DR. SE, SMYRNA 30080
WARNICK,LILLIAN P. 17 ACT PH
12 CAPITOL SQUARE NE, ATLANTA 30334
WEISMAN,EVAN B. 17 ACT I
50 PLAZA WAY, MARIETTA 30060
WILHELM,CHARLES C. 17 ACT I
792 CHURCH ST. EXT., MARIETTA 30060
WILLIAMS,MALCOLM H. 17 ACT I
3001 S. COBB DR., SMYRNA 30080
WILLIAMS,WILLIAM TALBERT 17 ACT
705 CONCORD RD., SMYRNA 30080
WOFFORD,BENJAMIN H.,JR. 17 ACT PL
684 CHEROKEE ST., MARIETTA 30060

18—COFFEE
(Coffee, Atkinson)

BELL,EUGENE D. 18 ACT
DOUGLAS 31533
BENSON,RICHARD L. 18 ACT R
BOX 1077, DOUGLAS 31533
COGDELL,B. H. 18 ACT FP
ALMA 31510
GILLIARD,FRED E. 18 ACT FP
WARD ST., DOUGLAS 31533
HARPER, MEREDITH 18 ACT OBG
1001 W. WARD ST., DOUGLAS 31533
HERNDON,JOHN W. 18 ACT FP
OCILLA RD., DOUGLAS 31533
JARDINE,DAN A. 18 ACT SU
DOUGLAS 31533
LEE, DUO LAM 18 ACT R
P.O. BOX 1077, DOUGLAS 31533
MCRAE,A.T.,JR 18 ACT SU
1004 W. WARD ST., DOUGLAS 31533
MEEKS,CALVIN STEWART,JR 18 ACT FP
DOUGLAS 31533
MOORMAN,LARRY R. 18 ACT OPH
221 SHIRLEY AV., DOUGLAS 31533
PARKER,T. L. 18 ACT SU
DOUGLAS 31533
RUDOLPH,STEPHEN J.,JR. 18 ACT IND
702 N. GASKIN AVE., DOUGLAS 31533
RUSSELL,ROGER K. 18 ACT FP
P.O. BOX 779, PEARSON 31642
STAPLETON,TOMMY K. 18 ACT FP
WESTSIDE DR., DOUGLAS 31533
WHITTLE,MICHAEL R. 18 ACT PATH
COFFEE GEN. HOSP., DOUGLAS 31533
WILLIAMS,JACK G. 18 ACT PD
BOX 568, DOUGLAS 31533
WILLS,WILLIAM R.,JR. 18 ACT FP
SHIRLEY AVE., DOUGLAS 31533

19—COLQUITT

ADCOCK,DAVID W. 19 ACT OR
1414 S. MAIN ST., MOULTRIE 31768
CONGER,P. D. 19 ACT FP
MOULTRIE 31768
FLYNN,JAMES T.,JR. 19 ACT OALR
MOULTRIE 31768
FOKES,ROBERT E.,JR. 19 ACT OALR
MOULTRIE 31768
FUNDERBURKE,A. G. 19 DE1 FP
1935-4TH ST. SE, MOULTRIE 31768
GAY,FRANCIS M. 19 ACT FP
MOULTRIE 31768
HARRISON,WALTER E. 19 ACT FP
711 S. MAIN, MOULTRIE 31768
HARVEY,LOUIS R. 19 A PH
P. O. BOX 383, SANDERSVILLE 31082
HARWELL,C. W. 19 A PH
561 CANDLEWOOD DR., ST. MOUNTAIN 30083
HESTER,THOMAS R.,JR. 19 ACT SU
S. MAIN ST., MOULTRIE 31768
JOINER,R. M. 19 ACT PD
MOULTRIE 31768
KITCHENS,WILLIAM R. 19 ACT SU
717 COLONIAL VILLAGE, MOULTRIE 31768
LA CONTE,LEONARD P. 19 ACT R
BOX 608, MOULTRIE 31768
MCCOY,JOHN F. 19 ACT FP
MOULTRIE 31768
MCGINTY,W. R. 19 ACT SU
MOULTRIE 31768
MCLEOD,JOHN W. 19 ACT SU
223 S. MAIN ST., MOULTRIE 31768
MOORE,CHARLES R. 19 ACT OPH
1303 FOURTH ST. SW, MOULTRIE 31768
MURTHY,B. R. KRISHNA 19 ACT I
GRANT PLAZA, MOULTRIE 31768
NEWTON,W. M.,JR. 19 ACT I
MEDICAL CTR, THOMASVL HWY, MOULTRIE 31768
PAULK,J. R. 19 ACT OALR
1320 5TH ST.,SW, MOULTRIE 31768
ROGERS,EDWARD A.,JR. 19 ACT OBG
700 S. MAIN, MOULTRIE 31768
TUCKER,JOHN P. 19 ACT FP
300 13TH AVE. SW, MOULTRIE 31768
WHITTLE,MICHAEL H. 19 ACT R

20—COWETA

ARNOLD,J. H. 20 DE1 FP
P. O. BOX 279, NEWNAN 30263
BARRON,WM. E. JR. 20 ACT I
P.O. BOX 609, NEWNAN 30263
BASS,F. DONALD 20 ACT SU
240 JACKSON ST., NEWNAN 30263
BRYANT,JAMES M.,JR. 20 ACT
NEWNAN 30263
BURNS,MATTHEW L. 20 ACT SU
15 CAVENDER ST., NEWNAN 30263
COLLINS,LEWIS R. 20 ACT I
P. O. BOX 609, NEWNAN 30263
FARMER,CHAS. W.,JR. 20 ACT OALR
P.O. BOX 160, NEWNAN 30263
FORBIS,SAMUEL E.,JR. 20 ACT R
P. O. BOX 997, NEWNAN 30263
GEERKEN,LUIS A. 20 ACT ANES
COWETA GENERAL HOSPITAL, NEWNAN 30263
GILBERT,FREDERICK E. 20 ACT PATH
COWETA GENERAL HOSP., NEWNAN 30263
GLOVER,HOWARD C.,JR. 20 ACT PD
NEWNAN 30263
GLOVER,N. B. 20 ACT PD
NEWNAN 30263
GRAHAM,THOMAS C. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263
HANNA,MICHAEL B. 20 ACT OPH
85 ACKSON ST., NEWNAN 30263
JARRARD,GEORGE T. 20 ACT I
P. O. BOX 609, NEWNAN 30263
JENKINS,BEN H. 20 ACT OALR
P. O. BOX 1120, NEWNAN 30263
JOHNSON,MARGARET W. 20 ACT PATH
P. O. BOX 20262, BIRMINGHAM, ALA 35216
MACNABB,GEORGE M. 20 ACT I
P.O. BOX 609, NEWNAN 30263
MANGET,FRED P. 20 DE5
3372 OSBORNE PL., MACON 31204
MCDONALD,R. H. 20 DE5 SU
114 LAGRANGE ST, NEWNAN 30263
MIKELL,JOEL E. 20 ACT R
BOX 981, NEWNAN 30263
PARKS,JOSEPH W.,JR. 20 ACT FP
P. O. BOX 609, NEWNAN 30263
POWELL,JACK H.,JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263
SOSBY,JOHN T. 20 ACT OBG
P. O. BOX 609, NEWNAN 30263
THOMASSON,JAMES J.,JR. 20 ACT SU
P.O. BOX 609, NEWNAN 30263
THOMPSON,ROBERT F. 20 ACT OALR
P.O. BOX 1155, NEWNAN 30263
WELLS,JOHN G. 20 ACT I
P.O. BOX 1099, NEWNAN 30263

21—DECATUR-SEMINOLE

BELLVILLE,CHAS. GEORGE 21 ACT SU
BAINBRIDGE 31717
BRECKENRIDGE,H. E.,JR. 21 ACT FP
HOSPITAL CIRCLE, DONALSONVILLE 31745
CARPENTER,R. S. 21 ACT SU
P.O. BOX 1110, BAINBRIDGE 31717
EHRLICH,M.A. 21 DE5 PD
231 E. BROUGHTON ST., BAINBRIDGE 31717
GIBSON,FRANK L. 21 ACT SU
BAINBRIDGE 31717
HOLLEY,JACOB H. 21 ACT FP
DONALSONVILLE 31745
MCNAIR,HAL 21 ACT FP
P.O. BOX 852, BAINBRIDGE 31717
REYNOLDS,MILTON B.,JR. 21 ACT FP
DONALSONVILLE CLINIC, DONALSONVILLE 31745
STARLING,ROBERT L. 21 ACT FP
MOSELEY CLINIC, DONALSONVILLE 31745
STEWART,CHARLES C. 21 ACT FP
P.O. BOX 371, DONALSONVILLE 31745
WALKER,CHARLES O. 21 ACT SU
SEMINOLE MEM. HOSP., DONALSONVILLE 31745
WOODS,E. ASHBY 21 ACT FP
BAINBRIDGE 31717
ZILIS,JAMES J. 21 ACT OBG
P.O. BOX 933, BAINBRIDGE 31717

22—DeKALB

ACKERMAN,ELLIOTT A. 22 ACT OR
365 WINN WAY, DECATUR 30030
ADAN,ANIBAL 22 ACT ANES
P.O. BOX 33247., DECATUR 30033
ALDRIDGE,STANLEY P. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
ALLARD,CHARLES 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
ALLEN,H. H. 22 DE5 FP
2343 HENDERSON MILL RD., ATLANTA 30342
ALLEN,LEE T. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
AMATRIAIN,F. F. 22 ACT OBG
340 BOULEVARD NE, ATLANTA 30312

ANTHONY,JAMES E.,JR. 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
APGAR,JOHN T. 22 ACT D
13 LAVISTA PER. OFC. PK., TUCKER 30084
ARNOLD,J. A. 22 ACT FP
2170 BRIARCLIFF RD. N.E., ATLANTA 30329
ARONOVITZ,GERSON H. 22 ACT PD
2714 CLAIRMONT RD. NE, ATLANTA 30329
ARTIME,MANUEL E. 22 ACT AL
1275 MCCONNELL DR., DECATUR 30033
ATKINS,EARNEST C. 22 ACT SU
2910 N. DRUID HILLS RD., ATLANTA 30329
AVRET,EDWIN T. 22 ACT I
4151 MEMORIAL DR.,105-B, DECATUR 30032
BALL,HORACE C. 22 ACT OBG
231 E. PONCE DE LEON, DECATUR 30030
BARIA,WILLIAM H. 22 ACT I
2895 N. DRUID HILLS RD. NE, ATLANTA 30329
BARTON,EARL G.,JR. 22 ACT PATH
2701 N. DECATUR RD., DECATUR 30030
BATH,NICHOLAS M. 22 ACT U
755 COLUMBIA DR.,STE. B, DECATUR 30030
BELCHER,WILLIAM T.,JR. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30033
BILLIPS,WILLIAM C. 22 ACT OPH
3576-D CHAMBLEE-TUCKER RD., ATLANTA 30341
BLACK,PAUL W. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BLACKSTON,RONALD D. 22 ACT PD
1365 CLIFTON RD. NE, ATLANTA 30322
BLAIR,H. DUANE 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
BOBO,W. EARL 22 ACT SU
365 WINN WAY, DECATUR 30030
BOWCOCK,JAMES Z. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
BRANAN,WM. J.,JR. 22 ACT PD
1989 N. WILLIAMSBURG DR., DECATUR 30033
BRANNEN,JAMES O. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033
BREIBANT,SIDNEY 22 ACT PD
11 LAVISTA PER. OFC. PK., TUCKER 30084
BRICE,ANTON,JR. 22 ACT I
542 CHURCH ST., DECATUR 30030
BROOKS,BETTY ANN 22 ACT OBG
365 WINN WAY, DECATUR 30030
BROOKS,COURTNEY C. 22 ACT FP
2223 CANDLER ROAD, DECATUR 30032
BROWNE,THOMAS MORGAN 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
BUCHANAN,L. C. 22 ACT SU
374 W. PONCE DE LEON AVE., DECATUR 30030
BURNETT,STACY W. 22 ACT PD
2100 PARKLAKE DR. NE, ATLANTA 30345
BUTTERWORTH,HENRY H. 22 ACT I
603 CHURCH STREET, DECATUR 30030
CARSPECKEN,HAROLD HUTSON 22 ACT PL
755 COLUMBIA DR., DECATUR 30030
CARTER,LEON,JR. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030
CASTLE,JOHN RICHARD 22 ACT OBG
231 E. PONCE DE LEON AVE., DECATUR 30030
CHANNA,G. H. 22 ACT PD
4705 LAWRENCEVILLE HWY., LILBURN 30247
CHRISTOPHER,PHILIP E. 22 ACT SU
365 WINN WAY, DECATUR 30032
CODINGTON,ARTHUR B. 22 ACT I
2647 CANDLER PKWY., DECATUR 30032
COFFSKY,JAY S. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
COLVIN,RICHARD S. 22 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
CONNER,WILLIAM C. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
COOPER,JERRY L. 22 ACT
3300 MEMORIAL DR., DECATUR 30032
COTTS,LEONARD L. 22 ACT I
3648 CHAMBLEE TUCKER RD., ATLANTA 30341
CRANK,R. PAUL 22 ACT I
755 COLUMBIA DR., DECATUR 30030
CRANMAN,JERARD S. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
CRISPIN,ROY H. 22 ACT TS
365 WINN WAY, DECATUR 30030
DALY,FRANK T.,JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
DAVIES,ROBERT L. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
DE BRA,DON W.,JR. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033
DIXON,JOHN M. 22 ACT OPH
12 LAVISTA PER. OFF. PK., TUCKER 30084
DOUGLAS,JOHN S.,JR. 22 ACT C
EMORY UNIVERSITY CLINIC, ATLANTA 30322
DOURRON,MARIA L. 22 ACT OBG

DOURRON,NESTOR W. 22 ACT FP
2900 GREENBROOK WYA, DECATUR 30030
DRESSLER,MARIAN S. 22 ACT PH
777 HOUSTON MILL RD. NE, #5, ATLANTA 30329
DUARTE,CARLOS R. 22 ACT PD
365 WINN WAY, DECATUR 30030
DUARTE,PATTY 22 ACT I
365 WINN WAY, DECATUR 30030
DULL,MARTHA KATHERINE 22 ACT OBG
4330 LAVISTA RD., TUCKER 30084
DUNCAN,G. A. 22 DE5 FP
714 S. CANDLER STREET, DECATUR 30030
DUNN,BYRON H. 22 ACT OBG
7 LAVISTA PER OFC PK,102, TUCKER 30084
EARLE,WALTER C. 22 DE5
2750 REDDING RD. NE, ATLANTA 30319
EAVES,ROBERT F.,JR. 22 ACT
2390 MAIN ST., TUCKER 30084
EDWARDS,F. KATHRYN 22 ACT R
4777 REBEL TRAIL NW, ATLANTA 30327
EDWARDS,PHILIP D. 22 ACT U
960 JOHNSON FERRY RD, #420, ATLANTA 30342
EIDEX,MARSHALL F. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
EIDEX,MAXWELL A. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30033
EITH,RONALD E. 22 ACT AL
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30341
ELLZEY,B. FRANK 22 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
ELLZEY,MILDRED JANE 22 ACT PD
5040 SNAPFINGER WOODS DR., DECATUR 30032
ESTES,J. W. 22 ACT VS
353 PARKWAY DR. NE, ATLANTA 30312
EVANS,J. RUFUS 22 DE5 FP
STONE MOUNTAIN 30083
FERNANDEZ,EZEQUIEL P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
FILARDI,GERALD A. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
FINE,ROBT. M. 22 ACT D
755 COLUMBIA DR., DECATUR 30030
FISHMAN,LEONARD 22 ACT D
2754 N. DECATUR RD., DECATUR 30030
FITE,J. DONALD 22 ACT OPH
542 CHURCH ST., DECATUR 30030
FLEMING,SIDNEY H. 22 ACT P
1256 BRIARCLIFF RD. NE, ATLANTA 30306
FOKES,ERNEST C. 22 ACT NS
365 WINN WAY, DECATUR 30030
FOSTER,H. R. 22 ACT PD
7660 COVINGTON HWY., LITHONIA 30058
FREEMAN,LAWRENCE L. 22 ACT
3652 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
FREGOSI,ALBERT H. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
FRISTOE,JOHN W.,JR. 22 ACT OBG
1551 MASON MILL RD. NE, ATLANTA 30329
FUERST,JULIAN F. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030
GALLER,EDWIN J. 22 ACT I
2054-G LAWRENCEVILLE HWY, DECATUR 30033
GANN,JOYCE A. 22 ACT OBG
365 WINN WAY, DECATUR 30030

GIBBS,R. I.,JR. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033
GIRARDEAU,HERBERT S.,JR 22 ACT SU
1270 MCCONNELL DR., DECATUR 30033
GRANT,R. PERRY 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GRAY,JAMES R. 22 A PD
69 BUTLER ST. SE, ATLANTA 30303
GRIFFIN,JOHN B.,JR. 22 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
HARDCASTLE,WILLIAM R. 22 ACT SU
9 LAVISTA PERIMETER OFC. PK., TUCKER 30084
HARDEN,TIMOTHY,JR. 22 ACT I
711 CHURCH STREET, DECATUR 30030
HARDY,WALLACE E. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084
HARREL,JOHN A.,JR 22 ACT AD
2701 N. DECATUR RD., DECATUR 30033
HARRISON,JOHN R. 22 ACT
5372 PEACHTREE RD., CHAMBLEE 30341
HATFIELD,HUGH A. 22 ACT FP
2064 P'TREE INDUSTRIAL CT., CHAMBLEE 30341
HEARD,JOHN P. 22 ACT FP
231 E. PONCE DE LEON AVE., DECATUR 30030
HOOSE,ELDON E. 22 ACT FP
3644 CHAMBLEE TUCKER RD., CHAMBLEE 30341
HOOSE,KENNETH A.,JR. 22 ACT I
1276 MCCONNELL DR., DECATUR 30033
HOWELL,EDGAR V.,JR. 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
HUBBELL,ROBT. W. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033
HUFF,PRENTIS BAKER 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
JANTER,THOMAS B. 22 ACT PD
4536 CHAMBLEE-DNWDY RD #201, CHAMBLEE 30341
JARDINA,PHILIP M. 22 ACT I
711 CHURCH ST., DECATUR 30030
JOHNSON,EDWARD L. 22 ACT OR
2910 N. DRUID HILLS RD., ATLANTA 30329
JOHNSON,LEWIS D. 22 ACT I
4303 LAVISTA RD., TUCKER 30084
JOINER,JAMES C.,III 22 ACT OPH
755 COLUMBIA DR., DECATUR 30030
JONES,ERNEST J. 22 ACT FP
2644 CANDLER PKWY., DECATUR 30030
JONES,FOREST D. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
JONES,GEORGE R. 22 ACT FP
3596 CHAMBLEE TUCKER RD., CHAMBLEE 30341
JOVE,JULIO 22 ACT OR
3644 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
KEENER,ELLIS B. 22 ACT NS
365 WINN WAY, DECATUR 30030
KEETON,WILLIAM F. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
KERLEY,CLIFFORD M. 22 ACT R
5247 FOREST SPRINGS DR., DUNWOODY 30338
KERR,WM. K. 22 ACT FP
P. O. BOX 80525, CHAMBLEE 30341
KINLAW,WM. K.,JR. 22 ACT NS
365 WINN WAY, DECATUR 30030
KNIGHT,EVELYN A. 22 ACT PD
3750 DIAL DR., CLARKSTON 30021
KRAMER,JOHN H. 22 ACT OPH
4555 N. SHALLOWFORD RD., ATLANTA 30341
LASSITER,NOLAN M. 22 ACT I
1275 MCCONNELL DR, DECATUR 30030
LEADER,EDWARD 22 ACT P
1970 CLIFF VALLEY RD. NE, ATLANTA 30329
LEE,HOWARD B. 22 ACT FP
603 CHURCH ST., DECATUR 30030
LEFF,PETER B. 22 ACT I
2054-F LAWRENCEVILLE HWY, DECATUR 30033
LEONARD,ROBERT P. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
LESLIE,JAMES T. 22 A PD
50 SEVENTH ST. NE., #404, ATLANTA 30323
LEVENSON,DAVID S. 22 ACT OPH
2754 N. DECATUR RD., DECATUR 30030
LITTON,JAMES H. 22 ACT FP
4173 FIRST AVE., TUCKER 30084
LOBEL,A. BEATA 22 ACT PD
11 LA VISTA PER OFC PK, TUCKER 30084
LONG,W. NEWTON 22 ACT OBG
80 BUTLER ST. SE, ATLANTA 30303
LOWRY,THOMAS 22 ACT
2701 N. DECATUR RD,, DECATUR 30033
LUCKETT,JAMES M. 22 ACT R
2701 N. DECATUR RD., DECATUR 30030
LYNN,KAY F. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30032
MACKEY,DAN M. 22 ACT D
4511 CHAMBLEE DUNWOODY RD., ATLANTA 30319
MAGEE,KENNETH G. 22 ACT PD
4536 CHAMBLEE DUNWDY RD., ATLANTA 30341
MAHON,THOMAS M. 22 ACT PD
4112 E. PONCE DE LEON AVE., CLARKSTON 30021
MANSFIELD,DONALD L. 22 ACT OBG
3576 CHAMBLEE TUCKER RD., CHAMBLEE 30341
MASON,JAMES L. 22 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
MATHEWS,WAYNE S. 22 ACT PD
2100 PARK LAKE DR. NE, ATLANTA 30345
MATTHEWS,LAWRENCE P. 22 DE5 OBG
1357 OXFORD RD. NE, ATLANTA 30307
MATTHEWS,W. FRANK 22 ACT PATH
DEKALB GENERAL HOSP., DECATUR 30030
MATTISON,RICHARD C. 22 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342
MC ANULTY,MARTHA J. 22 ACT I
3081 MAPLE DR.,NE, ATLANTA 30305
MCCORMICK,GLENN E.,JR. 22 ACT D
755 COLUMBIA DR., DECATUR 30030
MCCUISTON,C. F. 22 ACT I
3610 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
MCCURDY,WILLIS T. 22 DE5 FP
P. O. BOX 336, STONE MOUNTAIN 30083
MCDOWELL,CHARLES W.,JR. 22 ACT OPH
542 CHURCH ST., DECATUR 30030
MCGINNIS,LAMAR S.,JR. 22 ACT SU
365 WINN WAY, DECATUR 30030
MCLANE,JOHN E. 22 ACT OBG
365 WINN WAY, DECATUR 30030
METZGER,C. ROBERT,JR. 22 ACT PD
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084
MICHAELS,JOHN 22 ACT PD
2100 PARK LAKE DR. NE, ATLANTA 30329
MILLER,CHESTER O. 22 ACT P
1970 CLIFF VALLEY WAY, ATLANTA 30322
MILSAP,JAMES H.,JR. 22 ACT R
2910 N. DRUID HILLS RD., ATLANTA 30329
MINOR,B. DONALD 22 ACT R
2256 SAGAMORE HILLS DR., DECATUR 30033
MOON,ELLIOTT C. 22 ACT OBG
5 LAVISTA PERIMETER PARK, TUCKER 30084
MOORE,MEL T. 22 ACT
3646 MARKET ST., CLARKSTON 30021
MORGAN,DAVID L. 22 ACT PD
1901 CENTURY BLVD., ATLANTA 30345
MORGAN,FRANK E.,JR. 22 ACT R
755 COLUMBIA DR., DECATUR 30030
MORGAN,Z. V.,JR. 22 ACT I
542 CHURCH ST., DECATUR 30030
MORSE,CHESTER W. 22 ACT I
711 CHURCH STREET, DECATUR 30030
MOSELEY,TEDDY C. 22 ACT OBG
365 WINN WAY, DECATUR 30030
MOUSSAKHANI,JOSEPH 22 ACT OBG
3041 ACCESS RD. NE EXP., CHAMBLEE 30341
NADAL,GUILLERMO 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
NAIB,Z. M. 22 ACT PATH
80 BUTLER ST. SE, ATLANTA 30303
NICHOLS,DAVID M. 22 ACT P
2871 CRAVEY DR., ATLANTA 30345
NODAL,RONALDO R. 22 ACT OBG
7 LA VISTA PER. OFC. PK., TUCKER 30084
OKEL,BENJAMIN B. 22 ACT I
2193 N. DECATUR RD., DECATUR 30033

OLKOWSKI,Z. L. 22 A R
WINSHIP CLN., EMORY UNIV., ATLANTA 30322
OQUIN,WILLIAM P. 22 ACT FP
2140 HENDERSON MILL RD., ATLANTA 30345
PARSONS,RICHARD C. 22 ACT ALR
755 COLUMBIA DR., DECATUR 30030
PAULK,E. ALAN,JR. 22 ACT I
6 LAVISTA PERIMETER OFC. PK., TUCKER 30084
PERKINS,JACK B. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
POWELL,F. C. 22 ACT I
3307 WILTSHIRE DR., AVONDALE ESTATES 30002
POWELL,RALPH W. 22 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
PRATER,R. BURT,JR. 22 ACT FP
4555 N. SHALLOWFORD RD., ATLANTA 30341
PRINCE,RUSSELL B. 22 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
PRINTZ,DON W. 22 ACT D
4303 LAVISTA RD., TUCKER 30084
PRUETT,JAMES E. 22 ACT ALR
755 COLUMBIA DR., DECATUR 30030
RAAEN,TOM D. 22 ACT PATH
DEKALB GENERAL HOSPITAL, DECATUR 30030
RAMSEY,JOHN E. 22 ACT OBG
755 COLUMBIA DR., DECATUR 30030
RANDALL,R. BEAUVAIS,JR. 22 ACT I
1989 N. WILLIAMSBURG DR., DECATUR 30032
RAUBER,ALBERT PAUL 22 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
RAWLS,WILLIAM J. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
RAY,WALKER L. 22 ACT PD
4112 E. PONCE DELEON AVE., CLARKSTON 30021
REICH,ROBERT A. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
REMY,HENRY 22 ACT PD
798 RAYS RD., STONE MOUNTAIN 30083
RHAME,MARLAN L. VAN 22 ACT P
755 COLUMBIA DR., DECATUR 30030
RHENEY,THEODORE B. 22 ACT FP
2701 N. DECATUR RD., DECATUR 30030
RICE,M. HOBSON 22 ACT OPH
542 CHURCH STREET, DECATUR 30030
ROGERS,J. V.,JR. 22 ACT R
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
ROSENBERG,RAYMOND 22 ACT PD
11 LAVISTA PERIMETER OFC. PK, TUCKER 30084
ROUNTREE,CLYDE B. 22 ACT P
755 COLUMBIA DR., DECATUR 30030
ROWELL,ROGER R. 22 ACT OPH
542 CHURCH ST., DECATUR 30030
ROWLAND,DAVID M. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
SANDERS,FLOYD R.,JR 22 ACT FP
603 CHURCH ST., DECATUR 30030
SAWYER,HORACE K.,JR. 22 ACT FP
2054 LAWRENCEVILLE HWY., DECATUR 30033
SCHNEIDERMAN,STEVEN M. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033
SCHREEDER,JOHN M. 22 ACT FP
3652 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
SEESE,PERRY G. 22 ACT P
2151 PEACHFORD RD., CHAMBLEE 30341
SESSIONS,GEORGE P. 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
SHAVIN,JOEL S. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084
SHOEMAKER,KENNETH E. 22 ACT P
500 WINN WAY, DECATUR 30030
SHOTTS,RON F. 22 ACT OTO
1989 N. WILLIAMSBURG DR., DECATUR 30033
SILVER,WILLIAM E. 22 ACT OTO
1770 OLD SPRNGHSE LN NE, CHAMBLEE 30341
SIMMONS,JOHN W.,III 22 ACT PD
4112 E.PONCE DE LEON AVE., CLARKSTON 30021
SIMMONS,M. FREEMAN 22 ACT FP
301 WOODVIEW DR., DECATUR 30030
SMITH,DOUGLAS 22 ACT OR
1405 CHURCH ST., DECATUR 30030
SMITH,MIRIAM F. 22 ACT P
1989 WILLIAMSBURG DR., DECATUR 30033
SMITH,W. P. 22 DE5 I
P.O. BOX 552, AVONDALE ESTATES 30002
SMOOT,RICHARD H. 22 ACT SU
P.O. BOX 174, DECATUR 30030
SOTUS,PETER C. 22 ACT SU
3606 CHAMBLEE-TUCKER RD., CHAMBLEE 30341
SPRUELL,WILLIAM H. 22 ACT I
2712 N. DECATUR RD., DECATUR 30033
STATHAM,GEORGE W. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021
STATON,JEAN STEWART 22 ACT I
2754 N. DECATUR RD., DECATUR 30033
STEVES,ELMA M. 22 ACT PD
3624 CHAMBLEE TUCKER RD., CHAMBLEE 30341
STEVES,SEVERO 22 ACT OBG
204 PIKE ST., LAWRENCEVILLE 30245
STOVALL,RUSSELL H.,JR. 22 ACT OTO
755 COLUMBIA DR., DECATUR 30030
STROM,CARL H. 22 ACT PM
5040 SNAPFINGER WOODS DR., DECATUR 30032
STUBBS,O. WYTCH,JR. 22 ACT FP
3628 CHAMBLEE TUCKER RD., CHAMBLEE 30341
STUBBS,TRAWICK H. 22 ACT PH
1287 OAKDALE RD., ATLANTA 30307
STUCKEY,KATHERINE 22 ACT ANES
P.O. BOX 33247, DECATUR 30033
SYN,WAI YUN 22 ACT I
2100 PARKLAKE DR. NE, ATLANTA 30345
SYRIBEYS,JOHN P. 22 ACT SU
3606 CHAMBLEE-TUCKER RD., CHAMBLE, 30341
TALBOTT,GEORGE D. 22 ACT I
500 WINN WAY, DECATUR 30030
TATUM,JOSEPH C. 22 ACT OR
755 COLUMBIA DR., DECATUR 30030
TAYLOR,JOHN EDWIN,JR. 22 ACT PD
4112 E PONCE DE LEON AVE., CLARKSTON 30021
TEATE,H. LUTEN,JR. 22 ACT PD
1901 CENTURY BLVD. NE, ATLANTA 30345
TENEBAUM,STANLEY M. 22 ACT PD
11 LAVISTA PERIMETER PARK, TUCKER 30084
TILLMAN,RALPH A. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30030
TINDALL,GEORGE T. 22 ACT N
1365 CLIFTON RD., ATLANTA 30322
TINDALL,SUZIE C. 22 ACT N
DECATUR N. PROF. BLDG., DECATUR 30030
TIPPINS,WM. C.,JR. 22 ACT OBG
5040 SNAPFINGER WOODS DR., DECATUR 30030
TRENT,R. M. 22 ACT FP
2054 LAWRENCEVILLE HWY, DECATUR 30033
TROTTER,JOHN F. 22 ACT FP
2054 LAWRENCEVILLE HIWAY., DECATUR 30033
TUGGLE,M. VIRGINIA 22 ACT I
1336 COLUMBIA DR., DECATUR 30032
TURNER,DANIEL R. 22 ACT I
755 COLUMBIA DR., DECATUR 30030
TURNER,DON W. 22 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
UEHLING,EDWARD R. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033
VANDIVER,ROY W. 22 ACT N
365 WINN WAY, DECATUR 30030
VINSON,T. O. 22 ACT PH
440 WINN WAY, DECATUR 30030
VINTON,L. M.,JR. 22 ACT FP
1043 LAKESHORE DR., AVONDALE ESTATES 30002
VOGLER,WM. R. 22 ACT I
2057 CLAIRMONT RD., DECATUR 30033
WADE,ROBERT C. 22 ACT
3371 COLUMBIA WOODS DR., DECATUR 30032
WALDEN,CHARLES W. 22 ACT P
1989 N. WILLIAMSBURG DR., DECATUR 30033
WALKER,JAMES A. 22 ACT U
755 COLUMBIA DR., DECATUR 30030
WALKER,JEROME M.,JR. 22 ACT N
755 COLUMBIA DR., DECATUR 30030
WALKER,JOHN W. 22 ACT OBG
365 WINN WAY, DECATUR 30030

WALKER,KNOX,JR. 22 ACT OR
1405 CHURCH ST., DECATUR 30030
WALKER,MOFFETT R.,JR. 22 ACT I
BOX 3210, ATLANTA 30302
WALKER,W. W.,III 22 ACT OBG
365 WINN WAY, DECATUR 30030
WALLACE,RUSSELL W.,JR. 22 ACT N
755 COLUMBIA DR., DECATUR 30030
WALZ,PETER D. 22 ACT I
2054-B LAWRENCEVILLE HWY., DECATUR 30033
WARD,CHARLES J. 22 ACT OBG
365 WINN WAY, DECATUR 30030
WARD,WILLIAM T.,JR. 22 ACT FP
231 E PONCE DE LEON AVE., DECATUR 30030
WATKINS,CHARLES B. 22 ACT FP
3543 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
WHITE,WM. P. 22 ACT PD
558 MEDLOCK RD., DECATUR 30030
WHITEHURST,JOHN O. 22 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
WHITSON,THEODORE C. 22 ACT PL
755 COLUMBIA DR., DECATUR 30030
WHYTE,H.J. 22 ACT D
1276 MCCONNELL DRIVE, DECATUR 30033
WILLIAMS,JAMES D. 22 ACT PD
4511 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
WILLS,S. ANGIER 22 ACT SU
755 COLUMBIA DR., DECATUR 30030
WILSON,HENRY H. 22 ACT PD
1510 OAK GROVE RD., DECATUR 30033
WYATT,SPARKMAN H. 22 ACT P
2017 DESMOND DR., DECATUR 30033
WYLIE,JAMES E. 22 ACT OBG
365 WINN WAY, DECATUR 30030
ZWEIG,ARNOLD 22 ACT OTO
3644 CHAMBLEE TUCKER RD., ATLANTA 30341

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(Baker, Dougherty, Lee)

ADAMS,WILLIE,JR. 23 ACT OBG
711 N. MONROE ST., ALBANY 31701
ARELLANO,BERNARD G. 23 ACT FP

ARMSTRONG,EDWARD S. 23 ACT I
223 THIRD AVE., ALBANY 31705
BATEMAN,J. DAN 23 ACT SU
410-12 FOURTH AVE., ALBANY 31705
BELFLOWER,ESTOL R. 23 ACT R
P.O. BOX 1924, ALBANY 31702
BERG,JOSEPH L. 23 ACT OPH
P. O. BOX 483, ALBANY 31702
BLACKSHEAR,JOSEPH R. 23 ACT EM

BOLTON,RICHARD S. 23 ACT PH

BOWMAN,M. B. 23 ACT SU
1104 N. MONROE ST., ALBANY 31705
BOYD,DONALD L. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701
BOYETTE,DAVID M. 23 ACT OTO
804 FOURTEENTH AVE., ALBANY 31705
BRIDGER,CLARENCE E. 23 ACT PATH
P.O. BOX 1828, ALBANY 31702
BRIDGES,WILLIAM H. 23 ACT R
P. O. BOX 1828, ALBANY 31702
BUCKNER,LESLIE MARVIN 23 DE5 FP
ROUTE 2, BOX 446, LEESBURG 31763
BUSH,LEON H. 23 ACT I
1009 N. MONROE, ALBANY 31701
CARTER,OTHA B.,JR. 23 ACT SU
810-13TH AVE., ALBANY 31701
CHASTAIN,GEORGE M. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702
COATES,GRAHAM 23 ACT P
1112 N. MADISON, ALBANY 31705
COLEMAN,WILLIAM MCL. 23 ACT OR
810 14TH AVE., ALBANY 31705
COLLINS,CHAPPELL A.,JR. 23 ACT FP
810 13TH AVE. , ALBANY 31701
CRIMMINS,L.T. 23 ACT SU
1009 N. MONROE, ALBANY 31701
DICKINSON,RICHARD F. 23 ACT R
P.O. BOX 1924, ALBANY 31702
DUNN,ROBERT G.,JR. 23 ACT R
P.O. BOX 1924, ALBANY 31702
FINDLAY,PRENTISS E. 23 ACT PD
HOUSTON MED CTR BOX 20780, HOUSTON TX 77030
FINNEY,C. E. 23 ACT OPH
521 THIRD AVE., ALBANY 31701
FLOURNOY,EDWIN E.,JR. 23 ACT FP
810 13TH AVE., ALBANY 31701
FOUNTAIN,T. GRAY 23 ACT SU
910 N. JEFFERSON, ALBANY 31705
FOWLER,MARK W. 23 ACT FP
1010 N. MADISON ST., ALBANY 31701
FREEMAN,ATWOOD M.,JR. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701
GEORGE,WILLIAM M.,JR. 23 ACT OBG
907 JEFFERSON ST., ALBANY 31707
GILLESPIE,CHARLES B. 23 ACT OR
810 14TH AVE., ALBANY 31701
GOLDSMITH,ABRAM O. 23 ACT OBG
P.O. BOX 714, ALBANY 31702
GORDON,WALTER C. 23 ACT SU
413 S. MADISON ST., ALBANY 31701
GRANT,JOHN R. 23 ACT OTO
804 14TH AVE., ALBANY 31705
GROVES,ROBERT H. 23 ACT FP
1100 N. MADISON ST., ALBANY 31701
GUILLEBEAU,F. DEMPSEY 23 ACT I
P. O. BOX 288, ALBANY 31702
HANCOCK,CARL V.,JR. 23 ACT U
810-13TH AVE., ALBANY 31701
HARPER,WILLIAM FERRELL 23 ACT SU
810-13TH AVE., ALBANY 31701
HATTAWAY,JAMES R. 23 ACT U
810-13TH AVE., ALBANY 31701
HILSMAN,P. L. 23 ACT OBG
1599 MEMORIAL DR. SE, ATLANTA 30317
HOLLIS,CHARLES D.,JR. 23 ACT I
P. O. BOX 288, ALBANY 31702
HOLMAN,C. M. 23 ACT OBG
410 FOURTH AVE., ALBANY 31705
HOOD,HERB L. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702
HUBBARD,JAMES A. 23 ACT OBG
401 S. MADISON, ALBANY 31701
INMAN,J. S.,JR. 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31705
ISELE,ANTHONY F. 23 ACT PATH
P. O. BOX 1908, ALBANY 31702
JARRELL,SHELBY E. 23 ACT EM
RT. 1,BOX 149P, BACONTON 31716
JOHNSON,THOMAS D. 23 ACT I
P. O. BOX 288, ALBANY 31702
KEITH,W. PERRY 23 ACT EM
2708 CAMBRIDGE RD., ALBANY 31707
KIM,TAE W. 23 ACT EM
2010 W. BROAD, ALBANY 31707
KLEMANN,GILBERT 23 ACT OBG
1021 15TH ST, AUGUSTA 30901
KLEMANN,GILBERT 23 ACT OBG
901 N. MADISON ST., ALBANY 31701
KNOWLES,VAN CISE 23 ACT SU
410 FOURTH AVE., ALBANY 31705
LAMB,CHARLES C. 23 ACT FP
910 N. JEFFERSON., ALBANY 31705
LANE,W. K. 23 ACT
810 13TH ST., ALBANY 31701
LEE,YEE W. 23 ACT PD
412 - FOURTH AVE., ALBANY 31705
LOWERY,WILLIAM D.,JR. 23 ACT NS
419 FOURTH AVE., ALBANY 31705
MARTIN,JAMES B. 23 ACT OBG
707 N. JEFFERSON STREET, ALBANY 31705
MATTHEW,ROBERT A. 23 ACT ANES
P. O. BOX 1828, ALBANY 31702

MAYHER,WILLIAM E.,III 23 ACT NS
419 FOURTH AVE., ALBANY 31705
MCCALL,CHARLES S.,JR. 23 ACT I
412 1/2 FOURTH AVE., ALBANY 31705
MCDANIEL,J. Z. 23 ACT U
C & S BANK BLDG., ALBANY 31701
MCKEMIE,W. FRANK 23 ACT
108 N. MONROE ST., ALBANY 31701
MCKINNEY,RAY L. 23 ACT R
P.O. BOX 1924, ALBANY 31702
MCLENDON,REMBERT L. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701
MEIER,JOHN A. 23 ACT OR
803 N. JEFFERSON ST., ALBANY 31701
MERREN,DAVID D. 23 ACT U
802 N. JEFFERSON, ALBANY 31705
MIDDLETON,FRANK F.,III 23 ACT OBG
907 N. JEFFERSON ST., ALBANY 31701
OGLESBY,JAMES W. 23 ACT TS
910 N. JEFFERSON ST., ALBANY 31705
PARISH,HAVNER H.,JR. 23 ACT U

PARKER,GREGG 23 ACT OBG
401-B MADISON AVE., ALBANY 31707
PASCHAL,J. DEAN 23 ACT PD
910 N. JEFFERSON ST., ALBANY 31705
RAWLINS,GEORGE M. 23 ACT EM
PHOEBE PUTNEY MEM. HOSP., ALBANY 31701
RAWLS,OTIS GREY 23 ACT SU
910 N. JEFFERSON, ALBANY 31705
RHYNE,WALTER P. 23 DE5 OALR
P. O. BOX 806, ALBANY 31702
RICHARDSON,R. C. 23 ACT OALR
400 4TH AVE., ALBANY 31705
ROBERSON,PHIL E. 23 ACT OBG
P. O. BOX 343, ALBANY 31702
SANTOS,TEODORO DE LOS 23 ACT PATH
P.O. BOX 1828, ALBANY 31702
SEYMOUR,GLENN E. 23 ACT SU
412 FOURTH AVE., ALBANY 31705
SHIRLEY,JACOB L.,JR. 23 ACT FP
411 S. MADISON ST., ALBANY 31701
SIMS,FRED E. 23 ACT ANES
107 S. JEFFERSON ST., ALBANY 31702
SUTTON,JAMES MACK,JR. 23 ACT PD
412 FOURTH AVE., ALBANY 31705
SWEAT,MAXWELL J.,JR. 23 ACT PD
1007-1ST AVE., ALBANY 31701
TALLEY,J. LECONTE,JR. 23 ACT OBG
901 N. MADISON ST., ALBANY 31705
THOMAS,FRANK E. 23 DE1 PD
12 SHERWOOD RD NW, FT. WALTON, FLA 32548
TRULOCK,ALBERT S.,JR. 23 ACT SU
800 N. JEFFERSON ST., ALBANY 31701
TURNER,DAVID A. 23 ACT P
420 4TH ST., ALBANY 31705
VAN DEVENTER,PHILLIP 23 ACT ANES
P.O. BOX 1828, ALBANY 31702
WALLER,ROBERT D. 23 ACT R
P.O. BOX 1924, ALBANY 31702
WILLIAMS,THEODORE G. 23 ACT OR
1105 PALMYRA RD., ALBANY 31701
WOLFE,DAVID M. 23 A PH
P. O. BOX 273, LEESBURG 31763
WOOD,CLAYTON E. 23 ACT D
1009 N. MONROE, ALBANY 31701
WOODARD,OTIS J.,JR. 23 ACT P
420-4TH ST., ALBANY 31705

24—CAMDEN-CHARLTON

DRURY,CARL M. 24 ACT FP
BOX DDD, ST. MARYS 31558
DUNBAR,GEORGE W. 24 ACT
P.O. BOX 767, ST. MARYS 31558
HARPER,CLARENCE H. 24 ACT
503 3RD ST., FOLKSTON 31539
JACKSON,JOSEPH M. 24 ACT FP
MCCOY-JACKSON HOSPITAL, FOLKSTON 31539
KEENE,WILLIS R. 24 ACT I
1001 N. THIRD ST., FOLKSTON 31537
MCCOLLUM,R. ROY,JR. 24 ACT
BOX 356, KINGSLAND 31548
OLIVEIRA,EDUARDO 24 ACT SU
%ROY MCCOLLUM,MD, KINGSLAND 31548
PEREA,JAIME 24 ACT P
1205 N. THIRD STREET, FOLKSTON 31537

25—EMANUEL

BROWN,R. G. 25 DE1 FP
SWAINSBORO 30401
FROST,H. R. 25 ACT FP
SWAINSBORO 30401
GILLIKIN,WILLIAM V.,P.C 25 ACT FP
TWIN CITY 30471
MEADOWS,CARTER LEE 25 ACT SU
P. O. BOX 879, SWAINSBORO 30401
MOYE,R. J. 25 ACT FP
SWAINSBORO 30401
SMITH,H. W. 25 ACT OB
SWAINSBORO 30401

26—FLINT
(Crisp, Dooly, Turner)

ADAMS,JOHN B,JR. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015
BARR,ROBERT E. 26 ACT FP
408 E. THIRD AVE., CORDELE 31015
BOBON,BENIGNO L. 26 ACT PATH
525 CEDAR CREEK DR., ATHENS 30601
BUSBEE,PERRY G. 26 ACT FP
CORDELE 31015
CHRISTMAS,JOSEPH T. 26 ACT FP
VIENNA 31092
COLEMAN,OTHA K. 26 ACT FP
CORDELE 31015
DINOLOV,JORDAN V. 26 ACT FP
P.O. BOX 232, ASHBURN 31714
GARRETT,ROBERT C. 26 ACT FP
412 CHURCH ST., VIENNA 31092
GOSS,CHRISTOPHER C. 26 ACT FP
ASHBURN 31714
GOSS,WOODROW 26 ACT FP
ASHBURN 31714
GREER,CHARLES C. 26 ACT OPH
BOX 1115, CORDELE 31015
MCARTHUR,CHARLES E. 26 DE5 FP
CORDELE 31015
PIRKLE,QUENTIN 26 ACT SU
P.O. BOX 10007, ATLANTA 30319
PIRKLE,T. N. 26 ACT R
P.O. BOX 1002, CORDELE 31015
REYNOLDS,JAMES WILEY 26 ACT FP
P.O. BOX 549, ASHBURN 31714
VASKO,TRUMAN L. 26 ACT SU
P.O. BOX 247, VIENNA 31092
VENABLE,ROBERT N. 26 ACT FP
403 15TH AVE., CORDELE 31015
WILLIAMS,P. L.,JR. 26 ACT FP
CORDELE 31015

27—FLOYD-POLK-CHATTOOGA

ADAIR,M. C. 27 ACT FP
FLOYD CO. HOSP., ROME 30161
ANDERSON,BENJAMIN S. JR. 27 ACT FP
P. O. BOX 508, CEDARTOWN 30125

ANDREWS,RUSSELL E. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161
ATHA,JOHN F. 27 ACT FP
HAGUE AVE., ROCKMART 30153
ATHA,WILLIAM J.,JR. 27 ACT
RT. 5, RIVERMONT RD, ROME 30161
AVERY,ANTHONY P. 27 ACT OTO
26 BALE ST., ROME 30161
BATTLE,LEE H.,JR. 27 ACT SU
321 W 7TH STREET, ROME 30163
BELL,SIDNEY A. 27 ACT OR
HARBIN CLINIC, ROME 30161
BLANCHARD,WILLIAM 27 ACT SU
CEDARTOWN 30125
BOSWORTH,E. L. 27 ACT I
HARBIN CLINIC, ROME 30161
BRANNON,EMMETT S. 27 ACT I
MCCALL HOSPITAL, ROME 30162
BRICE,BOYCE S. 27 ACT SU
THE HARBIN CLINIC, ROME 30161
BROCK,ROY CRAWFORD 27 ACT SU
14 PROFESSIONAL COURT, ROME 30161
CAMPBELL,RICHARD P. 27 ACT FP
1104 N. MAIN STREET, CEDARTOWN 30125
CATES,ROBERT M. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161
CAUTHEN,LARRY R. 27 ACT ANES
P.O. BOX 27, ROME 30161
COLLINS,JOHN T. 27 ACT OBG
206 HOSPITAL CIRCLE, ROME 30161
CONNELL,H. R.,JR. 27 ACT OALR
HARBIN CLINIC, ROME 30161
CONNOR,ROBERT T. 27 ACT FP
101 JOHN MADDOX DR., ROME 30161
CORPE,R. F. 27 ACT SU
BATTEY STATE HOSP., ROME 30161
CULBRETH,ERNEST W. 27 ACT FP
319 W. 6TH ST., ROME 30161
CUMMINGS,T. E. 27 ACT FP
121 E. MAPLE ST., ROCKMART 30153
DAVIDSON,GENE G. 27 ACT I
HARBIN CLINIC, ROME 30161
DAVIS,RALPH J. 27 ACT SU
P. O. BOX 2227, ROME 30161
DELLINGER,RAIDEN W. 27 ACT SU
321 W. 7TH ST., ROME 30163
DICKINSON,JOHN I. 27 ACT SU
310 W. SIXTH ST., ROME 30161
DIMOU,THEOFANIS G. 27 ACT FP
FLOYD HOSPITAL, ROME 30161
DIXON,HAMILTON S. 27 ACT ALR
15 JOHN MADDOX DR., ROME 30161
DOBBS,NELSON B.,JR. 27 ACT OPH
103 JOHN MADDOX BLVD, ROME 30161
DOHRMANN,DAVID M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
DOOLEY,WILLIAM D. 27 ACT R
P. O. BOX 2625, ROME 30161
EDGENS,JACK R. 27 ACT
RT. 5 HORSESHOE BEND, ROME 30161
ELLIOTT,C. B. 27 ACT SU
CEDARTOWN 30125
ESENER,ISMAIL 27 ACT OBG
P.O. BOX 418, MT. BERRY 30149
FARRELL,ROBERT A. 27 ACT PATH
FLOYD COUNTY HOSP., ROME 30161
FLOWERS,THOMAS EDWARD 27 ACT OPH
103 JOHN MADDOX DR., ROME 30161
GAFFORD,A. V. 27 ACT OPH
HARBIN CLINIC, ROME 30161
GATES,EDWARD M. 27 ACT NS
HARBIN CLINIC, ROME 30161
GIBBON,JOHN 27 ACT P
NW GA. REGIONAL HOSPITAL, ROME 30161
GILBERT,PETER G. 27 ACT U
HARBIN CLINIC, ROME 30161
GILBERT,WARREN 27 ACT FP
HARBIN CLINIC, ROME 30161
GOLDIN,HAROLD W. 27 ACT FP
ROCKMART 30153
GOODWIN,H. A.,JR. 27 ACT FP
SUMMERVILLE 30747
GRAY,ARTHUR R. 27 ACT SU
310 W. SIXTH ST., ROME 30161
HAEBERLE,MARK G. 27 ACT OBG
UNIV. KY MEDICAL CTR, LEXINGTON, KY 40504
HAJOSY,ELAINE L. 27 ACT ANES
P. O. BOX 27, ROME 30161
HAJOSY,LOUIS S.,JR. 27 ACT ANES
FLOYD HOSPITAL, ROME 30161
HARBIN,BANNESTER L.,JR. 27 ACT SU
HARBIN CLINIC, ROME 30161
HARBIN,LESTER 27 ACT SU
HARBIN CLINIC, ROME 30161
HARBIN,R. M.,JR. 27 DE5 SU
19 HORSELEG CREEK RD., ROME 30161
HARBIN,THOMAS S. 27 ACT OPH
HARBIN CLINIC, ROME 30161
HARBIN,W. P.,JR. 27 ACT I
HARBIN CLINIC, ROME 30161
HIERN,BARRIE C. 27 ACT ANES
122 SADDLE MOUNTAIN RD., ROME 30161
HINES,ROBERT C. 27 ACT FP
HARBIN CLINIC, ROME 30161
HORTMAN,H. C. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161
HOWSE,RALPH M. 27 ACT U
1825 MARTHA BERRY HWY., ROME 30161
HYDEN,WM. U. 27 ACT
TRION 30753
JACKSON,THOMAS W. 27 ACT OBG
326 MC CALL BLVD., ROME 30161
JENKINS,JAMES H. 27 ACT OBG
1142 E. CLUB LANE, ATLANTA 30319
JENKINS,O. W. 27 R FP
LINDALE 30147
KELLY,JAMES MARVIN 27 ACT OR
310 W. 10TH ST., ROME 30161
LEIGH,RICHARD W. 27 ACT OBG
16 PROFESSIONAL COURT, ROME 30161
LIPSIUS,L. H. 27 ACT P
1825 MARTHA BERRY BLVD., ROME 30161
LITTLE,G. H. 27 DE1 FP
TRION 30753
LLORENTE,TEODULO M. 27 ACT FP
13 JOHNS MADDOX DR., ROME 30161
LOVVORN,JOHN R. 27 ACT P
HARBIN CLINIC, ROME 30161
LUCAS,WILLIAM H. 27 ACT I
5 PROFESSIONAL CT., ROME 30163
MACLEOD, DAVID S. 27 ACT C
HARBIN CLINIC, ROME 30161
MARTENS,LESTER J. 27 ACT I
321 W. 7TH ST., ROME 30161
MATHENY,JAMES T. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
MCCALL,J. T.,JR. 27 ACT SU
MCCALL CLINIC, ROME 30162
MCGEHEE,JOHN M. 27 DE1 SU
BOX 277, CEDARTOWN 30125
MCMILLIAN,JAMES R. 27 ACT PD
HARBIN CLINIC, ROME 30161
MEACHAM,JACK R. 27 ACT FP
P. O. BOX 160, SUMMERVILLE 30747
MONTANA,EDUARDO 27 ACT
302 W. 6TH ST., ROME 30161
MOORE,C. W. C. 27 ACT I
304 E. 2ND. AVE., ROME 30161
MOORE,CLIFF,JR. 27 ACT SU
P.O. BOX 1108, ROME 30161
MOORE,W. L. 27 DE4

MORGAN,TOBBY S. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
MOSS,T. H. 27 ACT OBG
409 S. BROAD STREET, ROME 30161
MOSS,THOMAS H.,JR. 27 ACT FP
409 S. BROAD ST., ROME 30161
NORA,FELICIANO C. 27 ACT SU
FLOYD HOSP., ROME 30161

NORTON,R. F. 27 ACT OBG
10 HOSPITAL CIR., ROME 30161
OFFUTT,RANDOLPH 27 ACT OPH
325 W. 9TH ST, ROME 30161
PERKINS,G. E.,II 27 ACT PUL
HORSELEG ESTATES, ROME 30163
RATHUR,BABER Z. 27 ACT EM
2355 BOLTON RD.,NW, ATLANTA 30318
RHODES,E. LEEON 27 ACT SU
HARBIN CLINIC, ROME 30161
RICHARDS,CHARLES K. 27 ACT R
FLOYD HOSP., ROME 30161
RIGAS,LAMBROS C. 27 ACT OBG
206 HOSPITAL CIR., ROME 30161
ROUTLEDGE,JAMES A. 27 ACT SU
310 W. SIXTH ST., ROME 30161
SANCHEZ,ELIO S. 27 ACT I
BATTEY STATE HOSP., ROME 30161
SAPP,CLARENCE J. 27 ACT SU
200 E. 3RD ST., ROME 30161
SCHMIDT,DON 27 ACT FP
P. O. BOX 368, CEDARTOWN 30125
SELF,STANLEY J. 27 ACT D
302 W. 6TH ST., ROME 30161
SENNETT,CHARLIE O.,JR. 27 ACT PATH
FLOYD HOSP., ROME 30161
SMITH,CHARLES M. 27 ACT FP
ROCKMART 30153
SMITH,GARY L. 27 ACT FP
TRION 30753
SMITH,JAMES H. 27 ACT I
7 PROFESSIONAL COURT, ROME 30161
SMITH,LUCIUS S. 27 ACT R
FLOYD HOSPITAL, ROME 30162
SMITH,STEPHEN D. 27 ACT PD
10 HORSELEG CREEK RD., ROME 30163
SMITH,STUART A. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
SPIVEY,HERMAN E. 27 ACT FP
COMMERCE ST., SUMMERVILLE 30747
STARR,HARLAN M. 27 ACT PD
16 HOSPITAL CIRCLE, ROME 30161
STERGUS,INGRID 27 R PATH
316 MOUNT ALTO RD., ROME 30161
TATE,JOHN DREWRY 27 ACT FP
MCCALL CLINIC, ROME 30161
TODINO,JOEL D. 27 ACT I
HARBIN CLINIC, ROME 30161
WALDREP,JACK MARION 27 ACT U
101 JOHN MADDOX DR., ROME 30161
WATERS,RAYMOND O. 27 ACT OTO
15 JOHN MADDOX DR., ROME 30161
WEAVER,JERRY O. 27 ACT FP
502 N. MAIN ST., CEDARTOWN 30125
WILCOX,C. R. 27 ACT OBG
10 HOSPITAL CIRCLE, ROME 30161
WYATT,BARBARA 27 ACT I
3 PROFESSIONAL COURT, ROME 30161
WYATT,C. J.,JR. 27 ACT I
5 PROFESSIONAL COURT, ROME 30161
YOUNG,R. A. 27 ACT I
HARBIN CLINIC, ROME 30161

28—FRANKLIN-HART

BROWN,STEWART D.,JR. 28 ACT FP
200 FRANKLIN SPRINGS ST., ROYSTON 30662
CACCHIOLI,LOUIS G. 28 ACT FP
202 W. HOWELL ST., HARTWELL 30643
DAVIS,BILLY J. 28 ACT FP
GIBSON ST., HARTWELL 30643
FORD,WILLIAM C. 28 ACT FP
BOX 5, LAVONIA 30553
HARRIS,WESLEY W. 28 ACT FP
ROYSTON 30662
SULLIVAN,ROBERT F. 28 ACT
CARNESVILLE 30521
WILLIAMS,JOHN W.,JR. 28 ACT FP
LAVONIA 30553

29—MEDICAL ASSOCIATION OF ATLANTA

ABBOTT,OSLER A. 29 DE1 SU
3037 W. PINE VALLEY RD. NW, ATLANTA 30305
ABEND,MELVIN N. 29 ACT SU
6063 PEACHTREE PKWY., NORCROSS 30071
ABERNATHY,A. H.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
ABERNATHY,ERNEST W. 29 ACT SU
157 N. MAIN ST., JONESBORO 30236
ADAIR,HAROLD E. 29 ACT U
490 PEACHTREE ST. NE, ATLANTA 30308
ADAMS,CHARLES D. 29 ACT D
34 SEVENTH ST., NE, ATLANTA 30308
ADAMS,CHARLES P. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
ADAMS,ELISABETH K. 29 A I
1685 MASON MILL RD NE, ATL. 30329
ADERHOLT,HEWLETT EDWIN 29 ACT ANES
1968 PEACHTREE RD.,NW, ATLANTA 30309
AGNOR,E. B. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
AGUILAR,AGUSTIN 29 ACT ANES
5662 QUEENSBOROUGH DR. N.E., ATLANTA 30328
AHMANN,PETER A. 29 ACT PD
1365 CLIFTON RD. NE, ATLANTA 30322
AHN,YOUNG W. 29 ACT OBG
69 BUTLER ST. SE, ATLANTA 30303
AJOY,ANA B. 29 ACT ANES
114 ESSEX AVE.,N.W., ATLANTA 30339
AKIN,JOHN T.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
ALARCON,ALFREDO 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
ALDEN,HERBERT S. 29 DE5 D
3316 PIEDMONT RD. NE, ATLANTA 30305
ALDERETE,JOSEPH F. 29 S P
77L MCDONOUGH BLVD., SE, ATLANTA 30315
ALDERMAN,EARL L. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
ALEXANDER,HAROLD H. 29 ACT OR
6500 VERNON WOODS DR. NE, ATLANTA 30328
ALEXANDER,JAMES H. 29 ACT PD
5675 PEACHTREE-DUNWOODY RD., ATLANTA 30342
ALFRED,DEWITT C.,JR. 29 ACT P
80 BUTLER ST. SE, ATLANTA 30303
ALLAN,CHRISTOPHER J. 29 ACT PATH
1000 JOHNSON-FERRY RD., ATLANTA 30342
ALLEN,JOHN EDWARD,JR. 29 ACT PD
1649 CLEVELAND AVE., EAST POINT 30344
ALLGOOD,PIERCE 29 ACT OR
35 COLLIER RD. NW, ATLANTA 30309
ALLMAN,FRED L. 29 ACT OR
615 PEACHTREE ST. NE, ATLANTA 30308
ALPERIN,HERBERT 29 ACT PD
5675 PTREE:DUNWOODY RD., NE, ATLANTA 30342
ALPERN,ROBERT J. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
AMBROSE,SAMUEL S.,JR. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
AMERSON,J. RICHARD 29 ACT SU
EMORY UNIVERSITY CLINIC, ATLANTA 30322
AMMONS,JOHN C. 29 S N
1670 CLAIRMONT RD. NE, ATLANTA 30329
ANDERS,PATRICK L. 29 ACT OBG
2726 FELTON DRIVE, EAST POINT 30344
ANDERS,REBEKAH Y. 29 ACT FP
2726-A FELTON DR., EAST POINT 30344
ANDERSON,GROVER L. 29 ACT NS
4326 HARRIS VALLEY RD. NW, ATL 30342
ANDERSON,JOHN M. 29 ACT P
490 PEACHTREE ST. NE, ATLANTA 30308
ANDERSON,SAMUEL A. 29 DE5 P
2300 N. VIENNA, RUSTON, LA. 71270

ANDERSON,THOMAS J.,JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
ANDERSON,WILLIAM B. 29 ACT P
1970 CLIFF VALLEY WAY, NE, ATLANTA 30329
ANDRADE,J. ROBIN DE 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
ANSARI,AMIR H. 29 ACT OBG
300 BOULEVARD,NE, ATLANTA 30312
ANTON,BLANCA R. 29 ACT P
1970 CLIFF VALLEY WAY, N.E., ATLANTA 30329
ANTROBUS,LEROY C. 29 ACT PD
495 E. CROSSVILLE RD., ROSWELL 30075
APPEL,SIDNEY D. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
APPLE,DAVID F. 29 ACT OR
3200 HOWELL MILL RD., ATLANTA 30327
ARANGO,VIRGILIO A. 29 ACT PD
35 LINDEN AVE. NE., ATLANTA 30308
ARMSTRONG,CHARLES L. 29 ACT FP
5675 PTREE DUNWOODY N.E., ATLANTA 30342
ARNOLD,HARRY D.,JR. 29 ACT OPH
3280 HOWELL MILL RD STE 229, ATLANTA 30327
ARTEAGA,OLIVER 29 DE5 OALR
384 PEACHTREE ST. NE, ATLANTA 30308
ASHER,HAROLD 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
ASKREN,EDWARD L.,III 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
ASKREN,EDWARD L.,JR 29 ACT OPH
1293 PEACHTREE ST. NE., ATLANTA 30309
ATKINS,SAM O. 29 ACT U
2600 GORDON ROAD,SW, ATLANTA 30311
ATKINSON,GEORGE O. 29 ACT R
1405 CLIFTON RD.,NE, ATLANTA 30322
ATKINSON,STEWART 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
ATWATER,JOHN S. 29 ACT GE
478 PEACHTREE ST. N.E., ATLANTA 30308
ATWATER,JOHN S.,JR. 29 DE4 I
1920-26TH AVE. NW, ROCHESTER, MINN. 55901
AVERETT,JAMES E.,JR. 29 ACT OR
35 COLLIER RD. NW, ATLANTA 30309
AVERY,WILLIAM G. 29 ACT OBG
275 CARPENTER DR. NE, ATLANTA 30328
AYCOTH,EDWARD D. 29 ACT R
490 PEACHTREE ST #255-B, ATLANTA 30308
AYER,G. DARRELL,JR. 29 ACT PATH
BOX 12466, ATLANTA 30305
AZAR,GORDON J. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BACKERMAN,IVAN A. 29 ACT OBG
1311 CLEVELAND AVENUE, EAST POINT 30344
BAILEY,JAMES A. 29 ACT PM
2797 CAMPBELLTON RD. SW, ATLANTA 30311
BAILEY,M. THOMAS,JR. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BAIRD,JOSEPH B.,JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
BAIRD,L. STEPHENS 29 ACT SU
1835 DELOWE DR. S.W., ATLANTA 30311
BAKER,CHARLES R. F.,JR. 29 ACT SU
69 BUTLER ST. SE, ATLANTA 30303
BAKER,J. JAY 29 ACT ON
5675 PEACHTREE DNWDY RD NW, ATLANTA 30342
BALBONA,JOSE L. 29 ACT P
3316 PIEDMONT RD. NE, ATLANTA 30305
BALL,TURNER I. 29 ACT R
80 BUTLER ST SE, ATLANTA 30303
BALLARD,MARGUERITE C. 29 ACT I
3092 ARGONNE DR. NW, ATLANTA 30305
BANCKER,EVERT A.,JR. 29 DE1 I
125 RIVER NORTH DR. NW, ATLANTA 30328
BANNISTER,JAMES P. 29 ACT P
478 PEACHTREE ST.,NE, ATLANTA 30308
BARKSDALE,C. R.,JR. 29 ACT FP
44 SMITH ST., FAIRBURN 30213
BARNES,JOHN J. 29 ACT OBG
2045 PEACHTREE RD. NE, ATLANTA 30309
BARNES,JOSEPH H. 29 ACT OBG
5675 P-TREE-DNWDY RD,NE, ATLANTA 30342
BARNETT,CRAWFORD F.,JR. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
BARNETT,JOHN E.,JR. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
BARNETT,STEPHEN T.,JR. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
BARROW,J. GORDON 29 ACT I
938 PEACHTREE ST. NE, ATLANTA 30309
BARTHOLOMEW,PHILIP R. 29 ACT OBG
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
BASKIN,J. HAGIN,JR. 29 ACT SU
490 PEACHTREE ST. N. E., ATLANTA 30308
BATEMAN,NEEDHAM B. 29 ACT SU
401 PEACHTREE ST. NE, ATLANTA 30308
BAUMGARTNER,BRUCE R. 29 ACT R
1365 CLIFTON RD,NE, ATLANTA 30322
BAYNE,LOUI G. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BEACH,WILLIAM R.,III 29 ACT PATH
2550 WINDY HILL RD,STE 201, MARIETTA 30062
BEARD,DONALD E. 29 DE1 U
400 LOG CABIN DR., SMYRNA 30080
BEASLEY,ERNEST W.,JR. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BECERRA,HERNAN 29 ACT FP
2741 BAYARD ST., EAST PT. 30344
BELL,FRANK C. 29 ACT OPH
1365 CLIFTON RD.,NE, ATLANTA 30322
BELL,FRED M.,JR. 29 ACT SU
6640 BARTON RD., MORROW 30260
BELL,HUGH V.,JR. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344
BENNETT,W. FRED,JR. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30327
BENNETT,WM. H. 29 R U
829 W. WESLEY RD. NW, ATL. 30327
BERGER,MERTON B. 29 ACT P
5600 ROSWELL RD. NE, ATLANTA 30342
BERGHERM,BRUCE A. 29 ACT ANES
1968 PEACHTREE RD. NW, ATLANTA 30309
BERMAN,JEROME D. 29 ACT PD
6500 VERNON WOODS RD. NE, ATLANTA 30328
BERN,GERHARD O. 29 S I
275-5TH ST. NW, ATLANTA 30332
BERNSTEIN,JEFFREY A. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
BERRY,C. MARKHAM 29 DE2 FP
4665 MYSTIC DR. NE, ATLANTA 30342
BERRY,JOSEPH N. 29 ACT I
6500 VERNON WOODS DR. NE, ATL. 30328
BERRY,MAXWELL R.,JR. 29 ACT GE
3250 HOWELL MILL RD.,NW, ATLANTA 30327
BICKERS,DONALD 29 ACT NS
3250 HOWELL MILL RD. NE, ATLANTA 30327
BIENERT,HENRY J. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
BIGGERS,WILLIAM H. 29 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
BILSTEN,GEORGE G. B. 29 ACT N
35 COLLIER RD. NW, ATLANTA 30309
BIRCH,HERBERT W. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
BISHOP,LINTON H.,JR. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
BIVENS,EDWARD S. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BIVINGS,F. LEE 29 DE5 PD
3110 HABERSHAM RD. NW, ATLANTA 30305
BLACK,CLYDE E. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
BLACK,JUDSON G. 29 ACT I
3250 HOWELL MILL RD.,NW,305, ATLANTA 30327
BLAINE,B. C. 29 ACT I
2034 MAIN STREET NW, ATLANTA 30318
BLALOCK,JOHN C. 29 DE5 SU
734 W. WESLEY RD. NW, ATLANTA 30327
BLALOCK,TULLY T. 29 ACT I
3280 HOWELL MILL RD,NW,217, ATLANTA 30327
BLANC,JAMES S. 29 ACT SU
1678 MULKEY RD., AUSTELL 30001

BLAND,JAMES W.,JR. 29 ACT ANES
1364 CLIFTON RD. NE, ATLANTA 30322
BLANK,SAMUEL 29 S
1670 CLAIRMONT RD NE, DECATUR 30033
BLASINGAME,JOHN T.,JR. 29 ACT SU
75 PIEDMONT AVE., NE, ATLANTA 30303
BLEICH,ALLAN C. 29 ACT I
5675 PTREE-DNWDY RD. NE, ATLANTA 30342
BLEICH,J. K. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
BLOCK,DONALD L. 29 ACT OBG
100 COLONY SQ., #1601, ATLANTA 30309
BLUMBERG,MAX M. 29 ACT I
33 PONCE DE LEON AVE. NE, ATLANTA 30308
BLUMBERG,RICHARD W. 29 ACT PD
69 BUTLER ST. S. E., ATLANTA 30303
BLUMENTHAL,IRVIN 29 ACT SU
384 PEACHTREE ST. N. E., ATLANTA 30308
BOATWRIGHT,MARTHA H. 29 ACT P
1970 CLIFF VALLEY WAY NE., ATLANTA 30329
BOGER,RICHARD E. 29 ACT PD
5675 PTREE-DUNWOODY RD, #502, ATLANTA 30342
BONDURANT,WILLIAM 29 ACT OR
478 PEACHTREE ST. NE, ATLANTA 30308
BONNER,JOHN T. 29 ACT ANES
69 BUTLER ST. SE, ATLANTA 30303
BOOTH,ARTHUR S. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BORDERS,JUEL PATE 29 ACT OBG
375 AUBURN AVE. SE, ATLANTA 30312
BORDON,JOSE ANTONIO 29 ACT ANES
159 FOREST AVE. NE, ATLANTA 30303
BOSTWICK,JOHN,III 29 ACT PL
25 PRESCOTT ST. NE, ATLANTA 30308
BOTTOMY,JOHN R. 29 ACT OBG
2794 WOODLAND PARK DR.,NE, ATL. 30329
BOWEN,EDWARD G. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BOWEN,ROBERT W. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236
BOYETT,JAMES E. 29 ACT TS
P. O. BOX 429, EAST POINT 30344
BRACKETT,J. GORDON 29 ACT ALR
340 BOULEVARD NE, ATLANTA 30312
BRACKETT,MORRIS E. 29 A
47 TRINITY AVENUE SW, ATLANTA 30303
BRADDOCK HENRY A. 29 ACT FP
1862 PRINCETON AVE., COLLEGE PARK 30337
BRANNON,LAWRENCE T. 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BRANTLEY,MARVIN A. 29 ACT P
1365 CLIFTON RD. NE, ATLANTA 30322
BRANTLY,EDMUND B. 29 ACT R
20 LINDEN AVE. NE, ATLANTA 30308
BRASWELL,L. RENDER 29 R FP
143 W. PACE FERRY RD. NW, ATLANTA 30305
BRAWNER,JAMES N.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
BREGMAN,LARRY 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., ATLANTA 30341
BREWER,JOHN M.,JR. 29 ACT D
384 PEACHTREE ST., NE, ATLANTA 30308
BREWER,SPENCER S.,JR. 29 ACT I
1938 PEACHTREE RD. NW, ATLANTA 30309
BRIDGES,GLENN J. 29 ACT U
573 W. PEACHTREE ST.,NE, ATLANTA 30308
BRINSFIELD,DOROTHY 29 ACT PD
2236 SPRING CREEK RD., DECATUR 30033
BROOKS,W. SCOTT,JR. 29 ACT I
1365 CLIFTON RD NE, ATLANTA 30322
BROOME,HARRY L. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30328
BROWN, NYDA W. 29 ACT P
5075 GREEN PINE DR.,NE, ATLANTA 30342
BROWN,ALGIE C. 29 ACT D
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BROWN,BOBBY C. 29 ACT PATH
1968 PEACHTREE RD.,NW, ATLANTA 30309
BROWN,CHARLES E. 29 ACT I
21 EIGHTH ST. N. E., ATLANTA 30309
BROWN,CHARLES W. 29 ACT OR
478 PEACHTREE ST. NE, ATLANTA 30308
BROWN,COLEMAN M. 29 ACT P
1938 PTREE RD. NW., ATLANTA 30309
BROWN,H. EUGENE 29 DE1 I
622 PARK LN., DECATUR 30033
BROWN,HOWARD S. 29 ACT TS
6500 VERNON WOODS DR. NE, ATLANTA 30328
BROWN,JIMMY S. 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305
BROWN,LESTER A. 29 ACT ALR
490 PEACHTREE ST. N. E., ATLANTA 30308
BROWN,NELSON H. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
BROWN,NYDA W. 29 ACT P
5075 GREEN PINE DRIVE, NE, ATLANTA 30342
BROWN,ROBERT G. 29 ACT PL
1365 CLIFTON RD.,NE, ATLANTA 30322
BROWN,ROBERT H. 29 ACT ALR
3280 HOWELL MILL RD. NW, ATLANTA 30327
BROWN,ROBERT L. 29 ACT SU
1645 TULLY CIR, STE 126, ATLANTA 30329
BROWN,S. ROSS 29 DE1 ANES

BRUNER,BARBARA 29 A. PD
69 BUTLER ST. SE, ATLANTA 30303
BRUNT,GWYNNE T.,JR. 29 ACT R
3312 PIEDMONT RD. NE, ATLANTA 30305
BRYANT,MILTON F.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
BUNNEN,ROBERT L. 29 A SU
3312 PIEDMONT ROAD, NE, ATLANTA 30305
BURGE,DAN 29 ACT I
315 BOULEVARD N.E., ATLANTA 30312
BURNS,WILLIAM B.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
BURSON,E. NAPIER,JR. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BURTON,HERBERT W. 29 DE1 I
25 PRESCOTT ST.,NE, ATLANTA 30308
BUSEY,THOMAS J.,JR. 29 ACT U
2748-B FELTON DR., EAST POINT 30344
BUSH,CHARLES K. 29 R P
4425 HARRIS TRAIL, N.W., ATLANTA 30327
BUSH,O. B. 29 DE5 FP
57 RUMSON WAY NE, ATLANTA 30305
BUTLER,CHARLES W.,JR. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
BUTLER,RICHARD H. 29 S
P. O. BOX 20636, ATLANTA 30320
BUTLER,WALTER H. 29 ACT ANES
1110 VERNON SPGS. CT. NW, ATLANTA 30327
BYRD,M. DANIEL 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
BYRNES,WILLIAM F. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
CABEZAS, RODRIGO 29 ACT TS
4555 N. SHALLOWFORD RD., ATLANTA 30341
CABRERA-MENDEZ,FABIO 29 DE2 P
80 BUTLER ST. SE, ATLANTA 30303
CADIER,THOMAS R. 29 A
5095 PINE BARK CIRCLE, DUNWOODY 30338
CALHOUN,F. P.,JR. 29 ACT OPH
1365 CLIFTON RD. NE, ATLANTA 30322
CALLAWAY,GEORGE M.,JR. 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
CAMPBELL,WALLACE G. 29 ACT PATH
EMORY UN. SCH. OF MEDICINE, ATLANTA 30322
CAPLAN,DANIEL B. 29 ACT PD
69 BUTLER ST. SE, ATLANTA 30303
CAPLAN,J. LOUIS 29 R OTO

CARLISLE,O. B. 29 ACT OPH
3158 MAPLE DR. NE, ATLANTA 30305
CARLOCK,KELLER S. 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305
CARPENTER,JAMES L. 29 ACT P
510 OAK HILL CIRCLE, MARIETTA 30060
CARR,RICHARD D. 29 S PM
3744 PREAKNESS DR., DECATUR 30034

CARRINGTON,LOUIE H. 29 ACT PD
275 CARPENTER DR. NW, ATLANTA 30328
CARSON,JAMES MAXWELL 29 ACT
340 BOULEVARD NE, ATLANTA 30312
CARTER,A. W.,JR. 29 ACT FP
4932 PHILLIPS DR., FOREST PARK 30050
CARTER,JAMES A. 29 ACT OTO
35 COLLIER RD. NW, ATLANTA 30309
CARTER,SANDY B. 29 ACT I
1938 PTREE ST., NW #1502, ATLANTA 30327
CASEY,JESSE F. 29 A P
1929 N. RIDGEWAY RD. NE, ATLANTA 30329
CASON,WILLIAM M. 29 DE5 OALR
6566 GLENRIDGE DR. N.E., ATLANTA 30328
CATANZARO,MARSHALL J. 29 ACT R
3312 PIEDMONT RD. NE, ATLANTA 30305
CATHCART,DON F. 29 DE5 PD
490 PEACHTREE ST. N.E., ATLANTA 30308
CAUDILL,DARRELL R. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
CHAIT,DONALD C. 29 ACT I
490 PEACHTREE ST. N.E., ATLANTA 30308
CHALMERS,RIVES 29 ACT P
2905 PEACHTREE RD. N. E., ATLANTA 30305
CHAMBERS,BENJAMIN M. 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
CHANDLER,NEAL W. 29 ACT R
4680 RIVERVIEW RD.,NW, ATLANTA 30327
CHAPPELL,AMEY 29 DE5 I
3750 PEACHTREE ST. NE, ATLANTA 30319
CHELTON,ALICE G. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
CHELTON,L. GUY 29 ACT I
1999 CLIFF VALLEY WAY NE, ATLANTA 30329
CHEVES,H. L. 29 ACT FP
2726-B FELTON DR., EAST POINT 30344
CHORCHES,MICHAEL A. 29 ACT C
265 IVY ST. NE, ATLANT 30303
CHRISTY,JAMES H. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
CHYATTE,SAMUEL B. 29 ACT PM
EMORY UNIV. HOSP., ATLANTA 30322
CIBELLI,LOUIS A. 29 R R
257 COLONIAL HOMES DR. NW, ATLANTA 30309
CLAIBORNE,T. STERLING 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
CLAIR,ALVIN H. 29 ACT D
4720 OLD VILLAGE LN. NE, ATLANTA 30341
CLARK,JAMES E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
CLARK,NEWTON T.,JR. 29 ACT OR
275 CARPENTER DR. NE, ATLANTA 30328
CLEMENTS,J.L.,JR. 29 ACT I
4055 RANDALL MILL RD. NW, ATL. 30327
CLEMENTS,STEPHEN D. 29 ACT C
1365 CLIFTON RD. NE, ATLANTA 30322
CLINE,PETER J. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
CLINE,STEVEN G. 29 ACT G
1170 CLEVELAND AVENUE, EAST POINT 30344
CLINKSCALES,GRADY S. JR. 29 ACT OR
1938 PEACHTREE RD,NE,STE 603, ATLANTA 30309
COBB,CLAUD P.,JR. 29 ACT FP
1544 NISKEYLAKE TR., SW, ATLANTA 30331
COBBS,BEVERLY W.,JR. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
COBERLY,JAMES CHAPMAN 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
COHEN,DAVID M. 29 ACT OTO
6500 VERNON WOODS DR. NE, ATLANTA 30328
COHEN,I. R. 29 ACT PD
950 W. PEACHTREE ST. N. E., ATLANTA 30309
COHEN,MARSHALL 29 ACT D
490 PEACHTREE ST. NE, ATLANTA 30308
COHEN,PAUL G. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
COHEN,ROBERT A. 29 ACT I
2250 WINDY HILL RD., MARIETTA 30062
COHEN,SHELDON B. 29 ACT P
401 PEACHTREE ST. N. E., ATLANTA 30308
COLEMAN,REESE C.,JR. 29 ACT U
401 PEACHTREE ST. N. E., ATLANTA 30308
COLES,CLEO P.,JR. 29 ACT SU
2945 STONE HOGAN RD.CONN. SW, ATLANTA 30331
COLES,W. C. 29 ACT R
315 BOULEVARD,NE, ATLANTA 30312
COLLIER,HAL F. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
COLLINS,WILLIAM C. 29 ACT OR
275 CARPENTER DR. NE, ATLANTA 30328
CONRAD,CONSTANCE C. 29 A FP
1069 BURTON DR. NE, ATLANTA 30329
COOK,ARTHUR J. 29 ACT R
478 PEACHTREE ST. NE, ATLANTA 30308
COOK,ROGER P. 29 ACT
3957 RANDALL MILL RD,NW, ATLANTA 30327
COOK,WM. C.,JR. 29 ACT ANES
3113 FARMINGTON DR. NE, ATLANTA 30339
COOLEDGE,JOHN W. 29 ACT PD
4770 N. PEACHTREE RD., CHAMBLEE 30341
COOLEY,SARAH F. 29 A
3686 CREEKVIEW CIR., STONE MOUNTAIN 30083
COONEY,JAMES P. 29 R
3653 N. STRATFORD RD. NE, ATLANTA 30305
COOPER,CHARLES F.,JR. 29 R OPH
1851 COLLAND DR. NW, ATLANTA 30318
COOPER,FLOYD R.,JR. 29 ACT NS
2718 FELTON DR., EAST POINT 30344
COOPER,GERALD R. 29 S I
CDC CENTER, ATLANTA 30333
COOPER,HARRY A. 29 ACT I
3393 PTREE RD. NE, ATLANTA 30326
COOPER,LAWRENCE E. 29 ACT I
2540 WINDY HILL RD., MARIETTA 30062
COPLIN,PAULR., R. 29 A P
1445 MONROE DR.,NE,F-30, ATLANTA 30324
COPPEDGE,W. W. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
CORLEY,C. C. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
CORTES,JULIO P. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
COWAN,Z. S. 29 R FP
1179 CLIFTON ROAD NE, ATLANTA 30316
COWART,G. THOMAS 29 ACT U
384 PEACHTREE ST. N. E., ATLANTA 30308
COWEN,FREDERICK B. 29 ACT EM
501 FAIRURN RBURN RD.,SW, ATLANTA 30331
COX,GEORGE W. 29 A R
1365 CLIFTON RD.,NE, ATLANTA 30322
COX,ROSS J. 29 ACT FP
6363 ROSWELL RD. NE, ATLANTA 30328
CRAVER,JOE M. 29 ACT TS
25 PRESCOTT ST. NE, ATLANTA 30308
CRAWFORD,CLYDE L. 29 ACT SU
652 W. PEACHTREE ST. N. W., ATLANTA 30308
CRIDER,HARRY J.,JR. 29 ACT OBG
1135 SHERIDAN RD. NE, ATLANTA 30324
CROFT,THOMAS J. 29 ACT NS
2718 FELTON DR., EAST POINT 30344
CRONCE,PAUL C. 29 ACT D
3316 PIEDMONT RD,NE,STE 50, ATLANTA 30305
CROOMS,C.L. 29 ACT OR
960 JOHNSON FERRY RD.,NE, ATLANTA 30342
CROSS,JAMES LEE 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
CROW,ROBERT W. 29 ACT PL
3280 HOWELL MILL RD.,NW, ATLANTA 30327
CROWE,WILLIAM R. 29 ACT I
1218 WEST PACES FY RD, ATLANTA 30327
CRUISE,JOE S. 29 ACT PUL
384 PEACHTREE ST. N. E., ATLANTA 30308
CRUMBLEY,A. J.,JR. 29 ACT SU
2788 BAYARD ST., EAST POINT 30344
CRUTCHER,JAMES CARROLL 29 S
1670 CLAIRMONT RD. NE, DECATUR 30033
CUETO,JOSE R. DEL 29 ACT FP
2739 FELTON DR., EAST POINT 30344
CUMMINGS,ROBERT J.,JR. 29 A OR
300 BOULEVARD NE, ATLANTA 30312

CUNNINGHAM,ROBERT P. 29 ACT I
SOUTHERN BELL, BOX 2211, ATLANTA 30301
CURCIC,DESANKA V. 29 ACT PD
1029 RIDGE AVE.,SW, ATLANTA 30325
CURTIS,EARNEST M.,JR. 29 ACT OBG
275 CARPENTER DR., SANDY SPRINGS 30328
CURTIS,WALKER L. 29 DE1 I
P. O. BOX 87100, COLLEGE PARK 30337
DALRYMPLE,DAVID E. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
DANIEL,WM. W. 29 ACT OBG
5675 PTREE-DUNWOODY RD, NE, ATLANTA 30342
DAVENPORT,T. F. 29 DE5 PD
478 PEACHTREE ST. NE, ATLANTA 30308
DAVIDSON, JOHN A. 29 ACT OPH
478 PEACHTREE ST.,NE, ATLANTA 30308
DAVIDSON,EUGENE D. 29 ACT SU
1365 CLIFTON RD.,NE, ATLANTA 30322
DAVIDSON,JOHN K.,III 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
DAVIES,NICHOLAS E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
DAVIS,ALBERT M. 29 ACT I
75 PIEDMONT AVE. NE, ATLANTA 30303
DAVIS,DAVE M. 29 ACT P
1999 CLIFF VALLEY WAY NE, ATLANTA 30329
DAVIS,FLOYD L. O. 29 ACT OPH
2722-A FELTON DR., EAST POINT 30344
DAVIS,JOHN L.,III 29 ACT OPH
3200 HOWELL MILL RD. NW, ATLANTA 30327
DAVIS,JOSEPH R. 29 ACT FP
6701 ROSWELL RD. NE, ATLANTA 30328
DAVIS,M. BEDFORD,JR. 29 ACT SU
340 BOULEVARD N.E., ATLANTA 30312
DAVIS,MARVIN L. 29 ACT PD
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
DAVIS,R. CARTER,JR. 29 ACT I
1201 PTREE ST. NE, ATLANTA 30361
DAVIS,ROBERT S. 29 ACT OBG
2100 PARKLAKE DR. NE, ATLANTA 30345
DAVIS,SHELLEY C.,JR. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
DAVIS,THOMAS A. 29 ACT P
1999 CLIFF VALLEY WAY, ATL. 30329
DAVIS,WILLIAM A.,III 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
DAVIS,WILLIAM B. 29 R PD
2065 WALKER AVE., COLLEGE PARK 30337
DAVIS,WILLIAM S. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
DAVISON,ALEXIS H. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
DAWSON,JACK E.,JR. 29 DE4 I
2225 RIADA DR. NW, ATLANTA 30305
DE ARMAS,F.M. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
DE LA PERRIERE,ARMAND 29 ACT OBG
3626 CHAMBLEE TUCKER RD, CHAMBLEE 30341
DEAS,RALPH H. 29 DE1 OPH
3166 MAPLE DR., ATLANTA 30305
DEES,HOYT C. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
DEITCH,MILTON J. 29 ACT U
490 PEACHTREE STREET NE, ATLANTA 30308
DELASHMUTT,ROBERT E. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
DENIS,BRUNO 29 ACT FP
427 KING ARNOLD DR., HAPEVILLE 30354
DENMARK,L. D. 29 DE5 PD
5605 GLENRIDGE DR. N. E., ATLANTA 30305
DENNIS,BROWN W. 29 ACT I
35 COLLIER RD.,NW, ATLANTA 30309
DENNISON,DAVID B. 29 ACT I
3280 HOWELL MILL RD.,NW, ATLANTA 30327
DENSLER,JAMES F. 29 ACT SU
319 W. LAKE AVE., ATLANTA 30318
DEW,J. HARRIS 29 ACT SU
3250 HOWELL MILL RD. NW, ATLANTA 30327
DEW,J. HARRIS,JR. 29 ACT OPH
3158 MAPLE DR. NE, ATLANTA 30305
DIMON,JOS. H. III 29 ACT OR
1938 PEACHTREE RD. NW, ATLANTA 30309
DOBES,WILLIAM L.,JR. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308
DODD,JOHN S.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
DOMINY,DALE E. 29 ACT SU
3988 ASHENTREE DR., ATLANTA 30341
DORNEY,EDWARD R. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322
DOWDA,F. W. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
DOWLING,GEORGE BRACKETT 29 DE5 I
1 WEST COURT SQ. #300, DECATUR 30035
DOWMAN,CHARLES E. 29 ACT NS
478 PEACHTREE ST. N.E., ATLANTA 30308
DOWMAN,CORDELIA K. 29 A PD
2550 BROOKDALE DR. NW, ATLANTA 30305
DUBOIS,RICHARD E. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
DUFFELL,GORDON M. 29 ACT I
1365 CLIFTON RD.,NE, ATLANTA 30322
DULOCK,MALCOLM P. 29 ACT FP
1000 S. BUFORD HWY., NORCROSS 30071
DUNBAR,RONALD W. 29 ACT ANES
1365 CLIFTON RD.,NE, ATLANTA 30322
DUNBAR,WALTER S. 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308
DUNSTAN,EDGAR M. 29 DE5 I
710 PINETREE DR., DECATUR 30030
DURALDE,FERNANDO U. 29 ACT SU
2760 FELTON DR., EAST POINT 30344
DURRETT,DONALD M. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
DYCKMAN,EDWARD 29 ACT I
5632 WYSONG TR.,NE, DUNWOODY 30338
EATON,S. BOYD 29 ACT R
265 IVY ST., NE, ATLANTA 30303
EBERHART,CHARLES 29 DE1 U
1738 COUNCIL BLUFF DR., ATLANTA 30345
ECHEMENDIA,MARIANO M. 29 ACT OBG
384 PEACHTREE ST. NE, ATLANTA 30308
EDMONDSON,STEPHEN W. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338
EDWARDS,CHARLES H. 29 ACT
1000 JOHNSON FERRY RD.,NE, ATLANTA 30305
EDWARDS,WM. T.,JR. 29 ACT OPH
1218 W PACES FERRY RD. #104, ATLANTA 30327
EGAN,ROBERT L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
EHIK,JULIUS 29 ACT P
811 JUNIPER ST. NE, ATLANTA 30308
EHLERS,JAMES A. 29 ACT I
6500 VERNON WOODS DR,NE,B12, ATLANTA 30328
EHRLICH,JONATHAN S. 29 ACT OBG
5675 PEACHTREE-DUNWOODY RD., ATLANTA 30342
ELLIOTT,RALPH A. 29 A I
STUD HEALTH SERV. GA TECH, ATLANTA 30308
ELLIS,JOHN O. 29 ACT R
384 PEACHTREE ST. NE, ATLANTA 30308
ELMER,R. A. 29 ACT R
6500 VERNON WOODS DR. NE, ATLANTA 30328
ELSAS,LOUIS J. 29 A PD
EMORY UNIV. SCHOOL OF MED., ATLANTA 30322
ELSEA,WILLIAM R. 29 ACT PH
99 BUTLER ST. SE, ATLANTA 30303
ELSON,EILEEN F. 29 DE1 PATH
78 SHERIDAN DR., NE #10, ATLANTA 30305
ELSON,SHIA H. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30345
ENGELHARDT,SAMUEL M.,III 29 ACT OBG
710 PEACHTREE ST. NE, ATLANTA 30309
EPSTEIN,JACOB 29 ACT OBG
1175 PEACHTREE STREET NE, ATLANTA 30309
ERICKSON,PAUL T. 29 A PH
109 PARKWOOD LANE, DECATUR 30030
ERICSSON,JUDITH A. 29 ACT ANES
3372 LYNNRAY DR.,NE, ATLANTA 30340
ERKAN,N.V. 29 ACT PD
2730-B FELTON DR., EAST POINT 30344

ESTES,RICHARD C. 29 ACT U
35 COLLIER RD. NW, ATLANTA 30309
EUBANKS,OMER L. 29 ACT I
1143 ALPHARETTA ST., ROSWELL 30075
EUBANKS,WM. L. 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
EVANS,ALBERT L. 29 ACT SU
735 PIEDMONT AVE. N. E., ATLANTA 30308
EVANS,E. C. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
EVANS,WM. W. 29 DE1 I
450 ROCK SPRINGS RD. NE, ATLANTA 30324
EYZAGUIRRE,WM. A. 29 ACT C
5064 NANDINA LANE, DUNWOODY 30338
FARUQUI,A. M. A. 29 A C
549 PEACHTREE ST., APT. 703, ATLANTA 30308
FEIGENBAUM,ERNEST 29 A PH
620 PEACHTREE ST.,NE, ATLANTA 30308
FELDER,LOUIS H. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
FELDER,RICHARD E. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
FELLNER,DONALD W. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344
FELNER,JOEL M. 29 A C
GRADY MEM. HOSP., ATLANTA 30303
FERGUSON,IRA A.,JR. 29 A SU
EMORY UNIV. CLINIC, ATLANTA 30322
FERGUSON,WILSON J. 29 ACT SU
GENERAL MOTORS CORP., DORAVILLE 30340
FERRIS,HAROLD A. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308
FIEDOTIN,ARNOLDO 29 ACT I
265 IVY ST. NE, ATLANTA 30303
FINCH,HENRY M. 29 ACT PR
490 PEACHTREE ST. N. E., ATLANTA 30308
FINCHER,RONALD E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
FINEGAN,ROBERT FRANKLIN 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
FISH,JOHN S. 29 ACT OB
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
FISHER,J. EDWARD 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
FISHER,WM. R. 29 ACT ALR
490 PEACHTREE ST. NE, ATLANTA 30308
FITZHUGH,F. W.,JR. 29 ACT I
1938 PEACHTREE ROAD NW, ATLANTA 30309
FITZPATRICK,PAUL E. 29 ACT I
6185 JONESBORO RD., MORROW 30260
FLANAGAN,JAMES C. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
FLEISHER,ALAN S. 29 ACT NS
1365 CLIFTON RD.,NE, ATLANTA 30322
FLEMING,LAMAR L. 29 ACT OR
1365 CLIFTON RD.,NE, ATLANTA 30322
FLEMING,WILLIAM H. 29 ACT TS
1365 CLIFTON RD. NE, ATLANTA 30322
FLETCHER,GERALD F. 29 A I
300 BOULEVARD NE, ATLANTA 30312
FLINCHUM,DARIUS 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
FLORENCE,THOMAS J. 29 ACT U
255 WINDY HILL ROAD, MARIETTA 30062
FLOYD,EARL H. 29 DE1 U
3705 VERMONT RD. NE, ATLANTA 30319
FORBES,G. LESTER,JR. 29 ACT PATH
3200 HOWELL MILL RD,NW, ATLANTA 30327
FORSYTH,DOUGLAS H. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
FOWLER,C. DIXON 29 ACT PD
27 EIGHTH ST. N. E., ATLANTA 30309
FOWLER,MAJOR F. 29 DE5 U
620 PEACHTREE ST NE #505, ATLANTA 30308
FRANCH,ROBERT H. 29 ACT I
EMORY UNIV. CLINIC, ATLANTA 30322
FRANCK,GEORGE H. 29 ACT IND
64 PERIMETER CTR. EAST NE, ATLANTA 30346
FRANCO,NED M. 29 ACT U
960 JOHNSON FERRY RD. NE, ATLANTA 30342
FRANCO,RICHARD D. 29 ACT I
25 PRESCOTT ST., ATLANTA 30308
FRANK,MILTON,III 29 ACT I
1175 PEACHTREE ST. NE, ATLANTA 30309
FRANKLIN,ERNEST W. 29 ACT OBG
25 PRESCOTT ST. NE, ATLANTA 30308
FRAZIER,WESLEY T. 29 ACT ANES
475 WOODRUFF MEMORIAL BLDG., ATLANTA 30322
FREDERICKSON,EVAN L. 29 ACT ANES
ANES. DEPT., EMORY UNIV., ATLANTA 30322
FREEDMAN,MILTON H. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312
FREEMAN,LAWRENCE C.,JR. 29 ACT ANES
355 LINDBERG DR. NE, ATLANTA 30305
FREEMAN,MALCOLM G. 29 A OBG
463 KIRK RD., DECATUR 30030
FREEMAN,OLEN I. 29 ACT P
5064 NANDINA LN., DUNWOODY 30338
FRIEDEWALD,WM. F. 29 ACT I
1293 PEACHTREE ST. NE, ATLANTA 30309
FULGHUM,C. B.,JR. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
FULLER,GEO. W. 29 DE5 FP
2638 PEACHTREE RD. NE, ATLANTA 30305
FULMER,THOMAS E. 29 ACT P
1711 AIDMORE DR. NE, ATLANTA 30307
FUNK,F. JAMES,JR. 29 ACT OR
1938 PEACHTREE ROAD NW, ATLANTA 30309
FUNK,SIDNEY A. 29 ACT OBG
275 CARPENTER DR., ATLANTA 30329
FUNKHOUSER,W. L. 29 DE5 PD
47 PEACHTREE PARK DR. NE, ATLANTA 30309
GABLE,THOMAS W. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
GABLER,REGINA 29 ACT OBG
950 W. PEACHTREE ST. N. W., ATLANTA 30309
GALAMBOS,JOHN T. 29 ACT I
69 BUTLER ST. SW, ATLANTA 30303
GALLOWAY,WM. H. 29 ACT OBG
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
GALVIN,WM. H. 29 ACT ANES
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
GAMBRELL,W. ELIZABETH 29 DE5 I
384 PEACHTREE ST. N. E., ATLANTA 30308
GAMWELL,JOHN W. 29 ACT OR
25 PRESCOTT ST. NE, ATLANTA 30308
GARCIA,P. F. 29 ACT P
3316 PIEDMONT RD NE, ATLANTA 30305
GAY,BRIT B.,JR. 29 ACT R
1405 CLIFTON RD. NE, ATLANTA 30333
GAY,THOMAS BOLLING 29 DE1 PD
3042 W. PINE VALLEY RD. N.W., ATLANTA 30305
GECKLER,JOHN H. 29 ACT ANES
20 LINDEN AVE. NE, ATLANTA 30308
GEDNEY,LEIGH M. 29 S U
818 FED ANNEX, ATLANTA 30304
GEER,BRUCE R. 29 ACT GE
3250 HOWELL MILL RD NW #200, ATLANTA 30327
GERMAIN,A. H. 29 DE5 FP
259 ARROWHEAD BLVD., JONESBORO 30236
GERSHON,NATHAN I. 29 ACT OALR
340 BOULEVARD NE, ATLANTA 30312
GERTLER,PHILLIP E. 29 ACT I
1938 PEACHTREE RD. NW, ATLANTA 30309
GERTNER,HAROLD R.,JR. 29 ACT SU
35 COLLIER RD,NW,675, ATLANTA 30309
GHANI,CHARLES A. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
GHOLSON,A. R. 29 ACT ANES
180 LAUREL FOREST CIR. NE, ATLANTA 30305
GIBSON,SAM T. 29 A
FDA, BLDG 29, RM 118, BETHESDA, MD 20014
GILBERT,CHARLES A. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
GILES,BEN J. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
GILLESPIE,EUGENE J. 29 A D
47 TRINITY AVE. SW, ATLANTA 30334
GILLESPIE,ROBERT H. 29 ACT OBG
1938 PEACHTREE RD. NW, ATLANTA 30309

GILNER,DONALD M. 29 ACT AL
960 JOHNSON FERRY RD., ATLANTA 30342
GINSBERG,STEWART T. 29 R P

GIRARDEAU,JOSEPH L. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
GLADSON,JAMES E. 29 ACT I
37 WILLOWICK CT., DECATUR 30034
GLENN,WADLEY R. 29 ACT SU
35 LINDEN AVE. N. E., ATLANTA 30308
GLISSON,C. STEADMAN 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
GODWIN,JOHN THOMAS 29 ACT PATH
265 IVY STREET NE, ATLANTA 30303
GOLD,PERRY 29 A PD
2795 MRGRT MITCHELL DR. NW, ATL. 30327
GOLDEN,HOWARD A. 29 ACT OBG
970 HUNTER ST. SW, ATLANTA 30314
GOLDMAN,GILBERT C. 29 ACT D
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
GOLDMAN,JOHN A. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
GOLDMAN,MILTON S. 29 ACT U
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GOLDSTEIN,GORDON T. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
GOMEZ,FRANK 29 ACT SU
ARROWHEAD MEDICAL PLAZA, JONESBORO 30236
GOMEZ,JULIAN R. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
GONZALEZ,PABLO E. 29 ACT
4508 CHERIE GLEN TRAIL, ST. MT. 30083
GONZALEZ,VICTOR R. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
GORDON,STEPHEN F. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GRABLOWSKY,OSCAR M. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
GRADY,CHARLOTTE 29 ACT

GRADY,DONALD F. 29 ACT NS
1175 PEACHTREE ST. NE, ATLANTA 30309
GRADY,EDGAR D. 29 ACT
2788 BAYARD ST., EAST POINT 30344
GRAVANIS,MICHAEL B. 29 ACT PATH
703 WOODRUFF BLDG EMORY UNIV, ATLANTA 30322
GRAVES,RAPHAEL K. 29 ACT PATH
1000 JOHNSON FERRY RD. NE, ATLANTA 30345
GRAYDON,E. LEONARD 29 DE5 FP
101 3RD ST. NE, ATLANTA 30308
GREEN,BRUCE G. 29 ACT U
6500 VERNON WOODS DR.,NE, ATLANTA 30328
GREEN,EDMOND W. 29 ACT FP
3395 STEWART AVE., HAPEVILLE 30354
GREENBERG,IRVING L. 29 ACT SU
950 W. PEACHTREE ST. N. W., ATLANTA 30309
GREENBERG,JOEL I. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
GREGOROFF,STANLEY 29 ACT I
384 PEACHTREE ST. NE, ATLANTA 30308
GREGORY,HUGH H. 29 ACT SU
735 PIEDMONT AVE. NE, ATLANTA 30308
GRIFFIN,BASIL M.,JR. 29 ACT OR
960 JOHNSON FERRY RD. NE, ATLANTA 30342
GRIFFIN,JOHN M. 29 ACT PL
3280 HOWELL MILL RD NE #111, ATLANTA 30327
GRIMES,W. H.,JR. 29 ACT OB
5675 P'TREE-DNWDY RD,NE,110, ATLANTA 30342
GRISAMORE,J. M. 29 ACT SU
6500 VERNON WOODS RD. NE, ATLANTA 30328
GROSS,PETER R. 29 ACT I
384 PEACHTREE ST. NE, ATLANTA 30308
GROSSMAN,GILBERT D. 29 ACT I
25 PRESCOTT ST. NE, ATLANTA 30308
GUDE,A. V. 29 ACT ANES
3464 PINESTREAM RD. NW, ATLANTA 30327
GUFFIN,THOMAS N. 29 ACT SU
461 KING ARNOLD ST., HAPEVILLE 30354
GUSSACK,HAROLD A. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308
GUY,J. CANDLER 29 ACT U
1938 PTREE RD, NW, STE. 206, ATLANTA 30309
HABERMAN,MICHAEL A. 29 A P
1177 ZIMMER DR.,NE, ATLANTA 30306
HACKER,MORTIMER 29 ACT PATH
1330 W. PTREE ST. NW, ATLANTA 30309
HACKNEY,J. F. 29 DE1 PH
1611 MILL ACRES DR. SW, ATLANTA 30311
HAGLER,WILLIAM S. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
HAILEY,CHENAULT W. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308
HALL,HENRY L. 29 ACT P
EMORY UNIVERSITY, ATLANTA 30322
HALL,JOHN C. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
HALLMAN,B. L. 29 ACT I
69 BUTLER ST,SE, ATLANTA 30303
HALLMAN,HELEN W. 29 ACT ANES
159 FORREST AVE. NE, ATLANTA 30303
HALLUM,ALTON V. 29 DE5 OPH
3280 HOWELL MILL RD NW #207, ATLANTA 30327
HALLUM,ALTON V.,JR. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
HALTIWANGER,EARL 29 S U
1670 CLAIRMONT RD. NE, ATLANTA 30329
HAMFF,LEONARD H. 29 ACT I
478 PEACHTREE ST. N. E., ATLANTA 30308
HAMM,WM. G. 29 DE5 PL
3280 HOWELL MILL RD.,NW, ATLANTA 30327
HAMMONDS,WILLIAM D. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
HANCOCK,CHARLES I. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
HANCOCK,ROBERT K. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
HANES,O. EUGENE 29 ACT I
600 W. PEACHTREE ST. N. E., ATLANTA 30308
HANKEY,DANIEL D. 29 ACT I
490 PEACHTREE ST. N. E., ATLANTA 30308
HANNER,JAMES P. 29 DE5 PD
49-26TH ST. NE, ATLANTA 30309
HANSEN,ROBERT F. 29 S PH
2 EMMA LN. NE, ATLANTA 30305
HARASZTI,ALEXANDER 29 ACT SU
217 ARROWHEAD BLVD., JONESBORO 30236
HARASZTI,ROSALIE 29 ACT FP
217 ARROWHEAD BLVD., JONESBORO 30236
HARBIN, THOMAS S.,JR 29 ACT OPH
2004 PEACHTREE RD.,NW, ATLANTA 30309
HARDIN,FREDERICK F. 29 ACT D
1938 PEACHTREE RD. NW, ATLANTA 30309
HARDMAN,JOHN B. 29 ACT P
1938 P'TREE RD,NW,STE 505, ATLANTA 30309
HARLIN,JOYCE A. 29 A R
80 BUTLER ST. SE, ATLANTA 30303
HARPER,BYRON F.,JR. 29 ACT I
2741 BAYARD ST., EAST POINT 30344
HARPER,CHARLES R. 29 ACT AM
P. O. BOX 20787, ATLANTA 30320
HARPER,WILLIAM N. 29 ACT FP
75 PIEDMONT AVE. NE, ATLANTA 30303
HARRIS,BOAZ 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
HARRIS,J. FRANK 29 ACT I
384 PEACHTREE ST. N. E., ATLANTA 30308
HARRIS,JAMES B. 29 ACT OBG
1478 MOZLEY DR. SW, ATLANTA 30314
HARRIS,T. A. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
HARRISON,CHARLES E.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HARRISON,EUGENE O. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
HARRISON,JAMES HAROLD 29 ACT
490 PEACHTREE ST. N. E., ATLANTA 30308
HARTLEY,JOHN H.,JR. 29 ACT PL
3280 HOWELL MILL RD NW #111, ATLANTA 30327
HARTRAMPF,CARL R. 29 ACT PL
960 JOHNSON FERRY RD. NE, ATLANTA 30342

HASTY,LEWIS B. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
HATCHER,CHARLES R. 29 ACT TS
EMORY CLINIC, ATLANTA 30322
HATHCOCK,WM. C. 29 ACT OALR
401 PEACHTREE ST. NE, ATLANTA 30308
HAUCK,A. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
HAUGEN,HARRY T. 29 ACT FP
2391 SEWELL RD. SW, ATLANTA 30311
HAUN,COSMO L. 29 ACT R
EMORY UNIV. CLINIC, ATLANTA 30322
HAVERTY,JOHN RHODES 29 ACT PD
UNIVERSITY PLAZA, ATLANTA 30303
HAWK,JUDSON LOUIS,JR. 29 ACT PD
3162 PIEDMONT RD., NE, ATLANTA 30305
HEARIN,DAVID L. 29 ACT D
3158 MAPLE DR. N. E., ATLANTA 30305
HEATH,TIM RAY 29 ACT SU
3280 HOWELL MILL RD,327, ATLANTA 30327
HECHT,HOWARD L. 29 ACT OR
5675 P'TREE-DUNWOODY RD,NE, ATLANTA 30342
HEILMAN,RICHARD B. 29 ACT IND
BOX 13083, ATLANTA 30310
HEIN,DAVID E. 29 ACT I
340 BOULEVARD N. E., ATLANTA 30312
HENDEE,ARMAND ELKIN 29 ACT OBG
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HENDRIX,VERNON J. 29 ACT OBG
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
HENRY,J. LAMONT 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HERNANDEZ,R. J. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
HERNDON,EUCLID G.,JR. 29 ACT I
EMORY UNIVERSITY CLINIC, ATLANTA 30322
HERSH,THEODORE 29 ACT GE
1365 CLIFTON RD. NE, ATLANTA 30322
HERTELL,JOSEPH A. 29 ACT I
3001 N. FULTON DR. NE, ATLANTA 30305
HEWELL,GUY C. 29 DE5 OBG
1123 BERKSHIRE RD. NE, ATLANTA 30306
HILL,JULIUS N.,III 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
HILL,WM. H. 29 ACT SU
3280 HOWELL MILL RD,NW,201, ATLANTA 30327
HILSMAN,A. H.,III 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
HILSMAN,J. H. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
HINKLE,JAMES E. 29 ACT ANES
1000 JOHNSON FERRY RD., ATLANTA 30342
HIRT,ALFREDO 29 ACT U
490 PEACHTREE ST. NE, ATLANTA 30308
HOBBY,A. WORTH 29 DE5 PUL
490 PEACHTREE ST. NE, ATLANTA 30308
HOBBY,LOVIC W. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
HOCKENHULL,JOHN A. 29 ACT FP
P. O. BOX 188, NICHOLLS 31544
HOFFMAN,BYRON J. 29 ACT I
768 JUNIPER ST. N. E., ATLANTA 30308
HOFFMAN,JAMES C.,JR. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
HOFFMAN,JOSEPH J.,JR 29 ACT SU
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
HOLLAND,BERNARD C. 29 ACT P
EMORY UNIVERSITY HOSPITAL, ATLANTA 30322
HOLLOWAY,CHAS. E. 29 ACT SU
478 PEACHTREE ST. N. E., ATLANTA 30308
HOLLOWAY,GEORGE A. 29 DE5 OBG
2827 CAREYGATE,NW, ATLANTA 30305
HOLTON,JOHN B. 29 ACT R
35 BUTLER ST. SE, ATLANTA 30303
HOOD, E. WALTER 29 ACT I
275 CARPENTER DR.,NE, ATLANTA 30328
HOPKINS,WM. A. 29 ACT SU
1938 PTREE RD., NW #303, ATLANTA 30309
HORNBERGER,R. B. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
HOTALEN,WM. B. 29 ACT IND
3384 PTREE RD. NE, ATLANTA 30326
HOWARD,CHARLES K. 29 A SU
5084 N. PEACHTREE, DUNWOODY 30338
HOWARD,JAMES W. 29 R FP
1761 FONTAINE DR., JONESBORO 30236
HOWELL,BARBARA P. 29 ACT FP
620 PEACHTREE ST. NE, ATLANTA 30308
HOWELL,TOM S.,JR. 29 ACT SU
620 PEACHTREE ST. NE, ATLANTA 30308
HOWLAND,W. SLOCUM,JR. 29 ACT OR
3250 HOWELL MILL RD., NW , ATLANTA 30327
HUBBARD,DONALD E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
HUDGINS,HERBERT A. 29 S PH
50 SEVENTH ST. NE, ATLANTA 30323
HUDGINS,WILLIAM BAIRD 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
HUG,CARL C.,JR. 29 ACT ANES
69 BUTLER ST. SE, ATLANTA 30303
HUGER,WILLIAM,JR. 29 ACT PL
35 COLLIER RD. NW, ATLANTA 30309
HUGHES,D. JAMES 29 ACT I
755 COLUMBIA DR., DECATUR 30030
HUGHES,JOE L. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
HUGULEY,CHAS. M.,JR. 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
HUIE,RALPH A.,JR. 29 ACT I
774 CLEMONT RD. NE, ATLANTA 30306
HUMPHREYS,JOHN L. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
HUNTER,CONWAY W.,JR. 29 ACT OBG
3250 HOWELL MILL RD. NW, ATLANTA 30327
HURD,RICHARD A.,JR. 29 ACT OR
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
HURST,J. WILLIS 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
HUTCHINSON,J. R. B. 29 ACT OTO
144 PONCE DE LEON AVE. NE, ATLANTA 30308
HYDRICK,JOHN T. 29 ACT OBG
960 JOHNSON FERRY RD., #245, ATLANTA 30342
HYDRICK,PETER 29 ACT OBG
1100 CLEVELAND AVE., 201, EAST POINT 30344
HYERS,JOHN J. 29 ACT ANES
5 CHAUMONT SQUARE NW, ATLANTA 30327
HYMAN,BARRY N. 29 DE2 OPH
10119 BRIAR FOREST, HOUSTON, TX 77042
ISENBERG,SIDNEY 29 ACT P
44 25TH ST. NE, ATLANTA 30309
IVEY,JOHN C. 29 DE5 SU
BOX 309, MEANSVILLE 30256
JACKSON,ZACH W. 29 DE5 OPH
1956 N. RIDGEWAY RD. NE, ATLANTA 30345
JACOBS,JOHN L. 29 DE5 AL
490 PEACHTREE ST. NE, ATLANTA 30308
JACOBS,JULIAN 29 S I
VA HOSP., P.O. BOX 29457, ATLANTA 30329
JAEGER-LEE, DOROTHY S. 29 ACT P
165 1365 CLIFTON RD.,NE, ATLANTA 30322
JAFFE,STEVEN L. 29 ACT P
6500 VERNON WOODS DR. NE, ATLANTA 30328
JAMES,W. SCOTT 29 ACT PD
275 CARPENTER DR., ATLANTA 30328
JARMAN,JULIAN A. 29 S SU
P. O. BOX 29457, ATLANTA 30329
JARRETT,WM. H. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
JARVIS,JACK R. 29 S P
35 PUTNAM CIRCLE,NE, ATLANTA 30342
JERNIGAN,STERLING H. 29 ACT SU
3280 HOWELL MILL RD.,NW,201, ATLANTA 30308
JINICH,HORACIO 29 ACT GE
1365 CLIFTON RD.,NE, ATLANTA 30322
JOEL,CHARLES,JR. 29 S N
1670 CLAIRMONT RD. NE, DECATUR 30033
JOHNSON,C. V. 29 ACT P
2151 PEACHFORD RD., ATLANTA 30341
JOHNSON,CHARLES E. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30342

JOHNSON,EDWARD D. 29 ACT SU
3580 ATLANTA AVE., HAPEVILLE 30354
JOHNSON,HENRY C.,JR. 29 ACT R
35 COLLIER RD. NW, ATLANTA 30309
JOHNSON,JAMES A.,III 29 A R
5221 ESSEX FARMS LANE, STONE MOUNTAIN 30083
JOHNSON,L. MALCOLM 29 ACT FP
401 PEACHTREE ST NE #300, ATLANTA 30308
JOHNSON,MCCLAREN 29 ACT GE
478 PEACHTREE ST. NE, ATLANTA 30308
JOHNSON,R. JULIAN 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
JOHNSON,RICHARD HARDIN 29 ACT I
2045 PEACHTREE RD. NE, ATLANTA 30309
JOINES,IVERSON W.,II 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
JOLLEY,FLEMING L. 29 ACT NS
EMORY CLINIC BUILDING, ATLANTA 30322
JONES, BARRY N. 29 ACT P
1970 CLIFF VALLEY WAY,NE, ATLANTA 30329
JONES,ARTHUR B.,JR. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
JONES,CARL C.,JR. 29 ACT AL
3316 PIEDMONT RD., ATLANTA 30305
JONES,CHARLES M. 29 A FP
1264 BILTMORE DR.,NE, ATLANTA 30329
JONES,E. LADD,JR. 29 ACT OR
3250 HOWELL MILL RD. NW, ATLANTA 30327
JONES,ELLIS L. 29 ACT TS
1365 CLIFTON RD.,NE, ATLANTA 30322
JONES,GEORGE W.,JR. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
JONES,HERMAN D.,PH.D. 29 H
209 LEE DR., AUBURN, ALA. 36830
JONES,LEWIS E. 29 S I
1670 CLAIRMONT RD., DECATUR 30033
JONES,MERWOOD M. 29 ACT OBG
2945 STONE HOGAN RD CONN SW, ATLANTA 30331
JONES,NORMAN E. 29 ACT R
315 BOULEVARD,NE, ATLANTA 30312
JONES,R. LANIER 29 ACT I
2981 CHURCH ST., EAST POINT 30334
JONES,RICHARD B. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
JORDAN,W. DANIEL 29 ACT SU
490 PEACHTREE ST., #365-C, ATLANTA 30308
JOSEPH,ALFRED 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344
JOSEPHS,ALVIN D. 29 S I
1670 CLAIRMONT RD., DECATUR 30033
JOSEY,WILLIAM E. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
JOVE,DONNA F. 29 ACT PATH
1216 ARBOR VISTA DR. NE, ATLANTA 30329
JURKIEWICZ,MAURICE J. 29 ACT PL
1365 CLIFTON RD. NE, ATLANTA 30322
KAHLE,DAN BRUCE 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
KAHN,ERIC M. 29 ACT SU
353 PARKWAY,NE, ATLANTA 30312
KAHN,S. DAVID 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
KAPLAN,JOEL A. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322
KARASU,SUAT 29 ACT ANES
627 CHEROKEE ST., MARIETTA 30060
KARP,HERBERT R. 29 ACT N
1365 CLIFTON RD.,NE, ATLANTA 30322
KAUFMANN,GARY E. 29 ACT NS
2550 WINDY HILL RD. SE, MARIETTA 30062
KAUFMANN,JAMES A. 29 ACT I
950 W. PEACHTREE ST. N. W., ATLANTA 30309
KELLEHER,ROBERT M. 29 ACT D
6500 VERNON WOODS DR #D-8, ATLANTA 30328
KELLER,JAMES W. 29 ACT ON
1365 CLIFTON ROAD, NE, ATLANTA 30322
KELLEY,W. A. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
KELLY,JAMES D. 29 R SU
3113 LENOX RD., ATLANTA 30324
KELLY,ROBERT P.,JR. 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
KEMPER,CLIFTON G. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
KENNEDY,KAREL R. 29 ACT C
215 PIEDMONT AVE APT 709, ATLANTA 30305
KETRON,HUBERT W. 29 S I
304 WORTHINGTON DR., MARIETTA 30060
KIBLER,ROBERT F. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
KILEY,JAMES D. 29 ACT I
3250 HOWELL MILL RD. NE, ATLANTA 30327
KILPATRICK,WM. H. 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
KIM,CHYUNG M. 29 ACT PD
1468 S. INDIAN CREEK DR., ST. MT. 30083
KIM,H. HAHK 29 ACT PD
2788 BAYARD ST., EAST POINT 30344
KIM,JONG-IN 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
KING,DELUTHA H. 29 ACT U
2600 GORDON SW,, ATLANTA 30311
KING,J. DUDLEY 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
KING,JAMES T. 29 DE1 ALR
1890 W. PACES FERRY RD., ATLANTA 30327
KING,JAMES T.,JR. 29 DE2 SU
1287 CUMBERLAND RD., ATLANTA 30306
KING,RICHARD 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
KING,RICHARD E. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
KING,SPENCER B.,III 29 ACT C
EMORY UNIV. CLINIC, ATLANTA 30322
KING,STEPHEN 29 ACT PD
6500 VERNON WOODS DR., ATLANTA 30328
KIRCHNER,ARTHUR B. 29 ACT R
1365 CLIFTON RD.,NE, ATLANTA 30322
KISER,ELLEN FINLEY 29 DE5 P
210 PEACHTREE CIR. NE, ATLANTA 30309
KISER,WM. H.,JR. 29 DE5 P
210 PEACHTREE CIR. NE, ATLANTA 30309
KITAY,DAVID Z. 29 ACT OBG
17 PRESCOTT ST., ATLANTA 30303
KITE,J. H. 29 DE5 OR
490 PEACHTREE ST. N. E., ATLANTA 30308
KLAUS,RICHARD M. 29 ACT OR
2550 WINDY HILL RD., #208, MARIETTA 30062
KLEIN,LUELLA M. 29 ACT OBG
80 BUTLER ST. SE, ATLANTA 30303
KLERIS,GEORGE S. 29 A PH
220 FORREST LK. DR. NW, ATLANTA 30327
KLOPPER,RALPH M. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
KLOPSTOCK,WILLIAM J. 29 ACT P
3316 PIEDMONT RD. NE, ATLANTA 30305
KLOTZ,HUGH A. 29 ACT OPH
3316 PIEDMONT RD. NE, ATLANTA 30305
KLUGH,GEORGE F. 29 DE5 PATH
303 N. HORNER BLVD., SANFORD, N. C. 27730
KOENIG,RONALD H. 29 ACT N
2788 BAYARD ST., EAST POINT 30344
KONAKCI,YUKSEL 29 A PATH

KOZINN, MARK A. 29 ACT N
2788 BAYARD ST., EAST POINT 30344
KOZINN,MARK A. 29 ACT N
1680 MULKEY RD, AUSTELL 30001
KRAININ,MILTON JOSEPH 29 ACT I
1293 PEACHTREE ST. NE, ATLANTA 30309
KRAL,ROBERT A. 29 ACT OBG
2100 PARKLAKE DR. NE, ATLANTA 30345
KRUGMAN,PHILIP I. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
KUMIN,GERALD D. 29 ACT I
644 CHEROKEE ST., MARIETTA 30062
KURTZ,JOSEPH L. 29 ACT OR
401 PEACHTREE ST. NE, ATLANTA 30308
KUTNER,STEPHEN S. 29 ACT OPH
340 BOULEVARD NE, ATLANTA 30312

LACKEY,DIXON A. 29 ACT PD
440 OLD CREED RD.,NE, ATLANTA 30342
LAHMAN,ROSE A. 29 ACT OBG
950 W. PEACHTREE ST. NW, ATLANTA 30309
LAMIS,PANO A. 29 ACT SU
315 BOULEVARD,NE, ATLANTA 30312
LANDY,MICHAEL S. 29 ACT I
2739 FELTON DR., EAST POINT 30344
LANE,DONALD R. 29 ACT I
353 PARKWAY DR. NE, ATLANTA 30312
LANGFORD,JAMES F. 29 ACT FP
1143 ALPHARETTA ST., ROSWELL 30075
LANIER,BOB G. 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
LARAMORE,HERBERT F. 29 A PH
654 KIMBERLY LANE NE, ATLANTA 30306
LAROCHE,LAURENT P. 29 ACT OCM
2000 N.E. X-WAY, NORCROSS 30071
LAROSE,JAMES H. 29 ACT R
1170 CLEVELAND AVE., EAST POINT 30344
LATHAM,ELIZABETH B. 29 ACT PD
3185 WASHINGTON RD., EAST POINT 30344
LATHAN,SAMUEL R. 29 ACT I
1201 PTREE ST. NE, ATLANTA 30361
LAVIETES,PAUL A. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
LAWRENCE,GEORGE C. 29 ACT OBG
75 PIEDMONT AVE. NE, ATLANTA 30303
LEE,JOHN E. 29 ACT N
25 PRESCOTT ST., ATL. 30308
LEFKOFF,HAROLD J. 29 ACT OALR
340 BOULEVARD NE, ATLANTA 30312
LEHMAN,RONALD J. 29 ACT OR
4555 N. SHALLOWFORD RD, CHAMBLEE 30341
LEIGH,TED F. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
LELAND,TOM W. 29 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
LENTON,JOHN D. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
LEONARD,JAMES R. 29 ACT OTO
3280 HOWELL MILL RD NW #333, ATLANTA 30327
LEONARD,WILLIAM P. 29 ACT SU
3406 OLD PLANTATION RD. NW, ATL 30327
LEONARDY,JOHN G. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
LESESNE,ARTHUR E. 29 ACT I
353 PARKWAY NE, ATLANTA 30312
LESSER,JOSEPH M. 29 ACT FP
400 COLONY SQ, STE. 1605, ATLANTA 30361
LESTER,JESS C. 29 ACT OPH
478 PEACHTREE STREET NE, ATLANTA 30308
LESTER,WM. M. 29 ACT OB
5675 P'TREE-DNWDY RD,NE, ATLANTA 30342
LETTON,A. HAMBLIN 29 ACT SU
315 BOULEVARD NE, ATLANTA 30312
LEVIN,HAROLD B. 29 ACT D
1293 PEACHTREE ST. NE, ATLANTA 30309
LEVIN,JACK M. 29 ACT PR
340 BOULEVARD NE, ATLANTA 30312
LEVINE, MICHAEL S. 29 ACT GE
2550 WINDY HILL RD.,311, MARIETTA 30062
LEVINE,MICHAEL K. 29 ACT PD
6500 VERNON WOODS DR. NE, ATLANTA 30328
LEVINE,STANLEY H. 29 ACT OBG
3312 PIEDMONT RD. NE, ATLANTA 30305
LEVINE,STEPHEN B. 29 ACT PD
5675 P'TREE-DUNWDY RD. NE, ATLANTA 30342
LEVY,CHARLES E. 29 ACT P
3400 PEACHTREE ST. NE, ATLANTA 30326
LEVY,LOUIS K. 29 ACT I
2045 PEACHTREE RD.,NW, ATLANTA 30309
LEVY,MORENO Y. 29 DE5 FP
221 ROBINHOOD RD. NE, ATLANTA 30309
LEWIS,ERNEST L. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
LEWIS,JOHN R.,JR. 29 ACT PL
3316 PIEDMONT RD. NE, ATLANTA 30305
LICHTMAN,STANLEY 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
LIEVANO,ALVARO 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344
LIN,HUI-CHING Y. 29 A I
634 WILSON RD. NW, ATLANTA 30318
LINDSEY,I.L. 29 ACT N
960 JOHNSON FERRY ROAD, NE, ATLANTA 30342
LIPMAN,BERNARD S. 29 ACT I
1285 PEACHTREE ST. NE, ATLANTA 30309
LIPPITT,ALAN B. 29 S OTO
U.S. ARMY HOSPITAL, FT. MCPHERSON 30330
LIPSCOMB,J. WATTS 29 ACT I
6185 JONESBORO RD., MORROW 30260
LIPSCOMB,THOMAS L. 29 ACT
3580 ATLANTA AVE., HAPEVILLE 30354
LIPSITCH, IAN I. 29 ACT P
1365 CLIFTON RD.,NE, ATLANTA 30322
LOCKHART,ASA C. 29 A ANES
GRADY MEMORIAL HOSPITAL, ATLANTA 30303
LOFTMAN,BERT A. 29 ACT N
1680 MULKEY RD STE H, AUSTELL 30001
LOGAN,WILLIAM DEWEY,JR. 29 ACT TS
272 BOULEVARD NE, ATLANTA 30312
LOGUE,R. BRUCE 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
LONG,STEWART M. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
LONG,WILLIAM B. 29 ACT OPH
4303 LAVISTA RD., TUCKER 30084
LOPEZ,JOSE 29 ACT ANES
409 ARROWHEAD BLVD BLDG A, JONESBORO 30236
LOPEZ,ORLANDO O. 29 ACT U
2748 FELTON DR., EAST POINT 30344
LORD,CLYDE O. 29 ACT ANES
501 FAIRBURN RD. SW, ATLANTA 30331
LOUGHLIN,EDWARD C. 29 ACT OR
3316 PIEDMONT RD. NE, ATLANTA 30305
LOVELL,WOOD W. 29 ACT OR
321 W. HILL ST., DECATUR 30030
LOWANCE,DAVID C. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
LOWANCE,MASON I. 29 ACT AL
3312 PIEDMONT RD. NE, ATLANTA 30305
LOWENBERG,ROBERT I. 29 ACT SU
4444 AUSTELL RD., AUSTELL 30001
LUCAS,GEORGE W. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
LYON,DAVID B. 29 ACT P
2151 PEACHFORD RD., ATLANTA 30341
LYON,HARRY C. 29 ACT FP
537 MORELAND AVENUE SE, ATLANTA 30316
LYON,JAMES B. 29 ACT OBG
710 PEACHTREE ST.,NE, ATLANTA 30308
MABON,ROBERT 29 ACT NS
35 COLLIER RD. NW, ATLANTA 30309
MACDONELL,FRANK S. 29 ACT D
2756-A FELTON DR., EAST POINT 30344
MACHADO,M. D. 29 ACT ANES
1676 MULKEY RD., AUSTELL 30001
MACRIS,ALLEN G. 29 ACT TS
490 PEACHTREE ST. NE, ATLANTA 30308
MACWILLIAMS,PETER 29 ACT D
1000 ATL. WEST BLVD., LITHIA SPRINGS 30057
MAHAN,THOMAS P. 29 ACT ANES
3518 PACES PLACE NW, ATLANTA 30305
MAJOROS,MARTON 29 ACT ALR
2719 FELTON DR., EAST POINT 30344
MALLORY,JAMES D.,JR. 29 ACT P
3355 LENOX RD. NE, ATLANTA 30326
MALONE,THOMAS P. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
MALOY,WILLIAM C. 29 ACT I
272 BOULEVARD NE, ATLANTA 30312
MANCHESTER,THOS. P.,JR. 29 ACT OPH
35 COLLIER RD. NW, ATLANTA 30309
MANGET,J. D.,JR. 29 DE1 FP
26 THIRD ST. NW, ATLANTA 30308
MANIS,ROBERT 29 ACT P
3316 PIEDMONT RD.,NE, ATLANTA 30305
MANSOUR,KAMAL A. 29 ACT TS
1365 CLIFTON RD. NE, ATLANTA 30322

MARCUCCI,MIGUEL A. 29 ACT VS
2404 AUSTELL RD., AUSTELL 30001
MARCUS,NEAL W. 29 ACT OR
1365 CLIFTON RD.,NE, ATLANTA 30322
MARKS,THOMAS W. 29 ACT OR
340 BOULEVARD NE, ATLANTA 30312
MARMER,ROBERT H. 29 ACT OPH
777 CLEVELAND AVE.,SW, ATLANTA 30315
MARTIN,J. D.,JR. 29 A SU
230 ROBIN HOOD RD. NE, ATLANTA 30309
MARTIN,LOUIS G. 29 ACT R
793 CLIFTON RD. N.E., ATLANTA 30307
MARTIN,WILLIAM O.,III 29 ACT OPH
1938 PEACHTREE RD. NW, ATLANTA 30309
MASON,EDWARD MCK. 29 ACT SU
315 BLVD. N. E. STE. 532, ATLANTA 30312
MASON,W. ROY 29 ACT
EMORY UNIV. OFC. OF UNIV. PHY., ATL 30322
MASON,WILLIAM ALFRED 29 A PH
118 MARIETTA ST. NW, ATLANTA 30303
MASSEE,JOSEPH C. 29 DE5 I
21 8TH ST. N. E., ATLANTA 30309
MASSEY,JOE B. 29 ACT OBG
960 JOHNSON FERRY RD., ATLANTA 30342
MATHEWS,WILLIAM H. 29 A PATH
EMORY UNIV-PATH DEPT., ATLANTA 30322
MATTHEWS,SANFORD JOHN 29 ACT PD
1938 PEACHTREE ROAD NW, ATLANTA 30309
MAUGHON,JAMES S. 29 ACT SU
300 BLVD. NE, ATLANTA 30312
MAULDIN,JOHN T. 29 ACT SU
315 BLVD. NE, #528, ATLANTA 30312
MAYER,W. BREM,JR. 29 ACT N
25 PRESCOTT STREET, NE, ATLANTA 30308
MAYS,J. LAMAR 29 ACT OPH
3280 HOWELL MILL RD.,NW, ATLANTA 30327
MCCAIN,JOHN R. 29 ACT OBG
25 PRESCOTT ST. NE, ATLANTA 30308
MCCLATCHEY,WM. M. 29 DE2 FP
NAS ATLANTA, ATLANTA 30060
MCCLELLAND,W. SPENCE 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
MCCLURE,JOHN N. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
MCCLURE,ROBERT E. 29 DE1
9201 S.W. 45TH ST., MIAMI, FLA. 33165
MCCORD,CLINTON D.,JR. 29 ACT OPH
3280 HOWELL MILL RD. NW, ATLANTA 30327
MCCORD,DALE L. 29 ACT R
25 PRESCOTT ST. NE, ATLANTA 30308
MCCOY,JOHN M. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
MCCROSKEY,MARION M. 29 ACT ANES
144 PONCE DE LEON AVE. NE, ATLANTA 30308
MCDANIEL,J. G. 29 DE5 SU
820 W. WESLEY RD. NW, ATLANTA 30327
MCDANIEL,J. STUART 29 ACT OBG
1938 PEACHTREE RD., STE. 408, ATLANTA 30309
MCDONALD,H. P. 29 DE5 U
98 CURRIER ST. NE, ATLANTA 30308
MCDONALD,LAWRENCE P. 29 ACT U
1641 LONGWORTH BLDG, WASHINGTON, DC 20515
MCDONALD,LEWIS H. 29 ACT SU
3665 IVY RD., ATLANTA 30342
MCDONALD,ROBERT L. 29 ACT P
3390 PEACHTREE RD. NE, ATLANTA 30326
MCDONOUGH,L. ALLEN 29 ACT PD
1036 LINDBERG DRIVE NE, ATLANTA 30324
MCDOUGALL,WM. L.,JR. 29 ACT U
3250 HOWELL MILL RD. NW, ATLANTA 30327
MCFADDEN,I. J.,II 29 ACT P
5675 PEACHTREE-DNWOODY RD, ATLANTA 30342
MCGARITY,WM. C. 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
MCGINTY,A. PARK 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
MCGRAW,WALKER C. 29 ACT SU
4555 N. SHALLOWFORD RD., ATLANTA 30341
MCKEE,DAVID S. 29 ACT PD
3312 PIEDMONT AVE,NE, ATLANTA 30305
MCKENZIE,WM. J.,JR. 29 ACT OBG
1365 CLIFTON RD. NE, ATLANTA 30322
MCKINNEY,ALEXANDER S. 29 ACT N
1365 CLIFTON RD. NE, ATLANTA 30322
MCLARTY,WILLIAM T.,JR. 29 ACT P
1970 CLIFF VALLEY RD. NE, ATLANTA 30329
MCLEAN,DONALD C. 29 ACT AL
1938 PEACHTREE RD. NW, ATLANTA 30309
MCLENDON,F. EARL 29 ACT FP
75 PIEDMONT AVE. NE, ATLANTA 30303
MCLEOD,WALLACE N. 29 ACT D
340 BOULEVARD NE, ATLANTA 30312
MCNIECE,ESTELLE 29 DE5 PD
11 SEVENTEENTH ST. NE, ATLANTA 30309
MCNINCH,JOSEPH H. 29 A ACM
4565 ANGELO DR. NE, ATLANTA 30319
MCPHEETERS,HAROLD L. 29 ACT P
130 SIXTH ST. NW, ATLANTA 30313
MEEHAN,PETER L. 29 DE4 OR
13913 FLINT ROCK RD., ROCKVILLE, MD. 20853
MELTZER,HAROLD D. 29 ACT PATH
2736 FELTON DR., EAST POINT 30344
MENDELOFF,JOSEPH 29 S PATH
1670 CLAIRMONT RD. NE, DECATUR 30033
MERLIN,HARVEY E. 29 ACT U
2788 BAYARD ST., ATLANTA 30344
MERRILL,ARTHUR J. 29 ACT I
35 COLLIER RD.,NW, ATLANTA 30309
MERRILL,ARTHUR J.,JR. 29 ACT C
35 LINDEN AVE, ATLANTA 30308
MILLEDGE,ROBERT D. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
MILLER,GEORGE D. 29 ACT D
275 CARPENTER DR. NE, ATLANTA 30328
MILLER,JOSEPH I. 29 ACT C
25 PRESCOTT ST. N. E., ATLANTA 30308
MILLER,LILA BONNER 29 ACT I
768 JUNIPER STREET NE, ATLANTA 30308
MILLER,PRESTON R. 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
MINOR,H. W. 29 DE5 I
4665 PEACHTREE DUNWOODY RD., ATLANTA 30342
MINOR,JAMES B. 29 ACT I
960 JOHNSON FERRY RD. N.E., ATLANTA 30342
MITCHELL,JAMES K.,JR. 29 ACT ALR
6075 ROSWELL RD. NW, ATLANTA 30328
MITCHELL,MARVIN A. 29 ACT SU
3250 HOWELL MILL RD., ATLANTA 30327
MITCHELL,OTIS C. 29 ACT OBG
217 ARROWHEAD BLVD., JONESBORO 30236
MITCHELL,WM. E. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
MITCHELL,WM. E.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
MOKAL,ALBERT J. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30309
MOLKNER,KENNETH C. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
MONCRIEF,W. M. 29 DE5 FP
3293 HUNTERDON WAY-SOMERSET, MARIETTA 30062
MONFORT,JOHN M. 29 DE5 I
HILTON HEAD IS.,SC 29928
MOORE,B. WALDO,JR. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
MOORE,G. RICHARD 29 ACT OBG
1702 CLEVELAND AVE., EAST POINT 30344
MOORE,W. W. 29 ACT NS
1175 PEACHTREE ST. NE, ATLANTA 30309
MOORHEAD,CHRISTIAN R. 29 ACT OBG
75 PIEDMONT AVE. NE, ATLANTA 30303
MORAN,MARTIN J. 29 ACT PD
275 CARPENTER DR. NE, ATLANTA 30328
MORENO, HUGO S. 29 ACT OBG
2750-A FELTON DR., EAST POINT 30344
MORGAN,HORACE L. 29 ACT IND

MORGAN,JAMES W. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
MORRIS,ALBERT L. 29 ACT FP
65 W. CAMPBELLTON, FAIRBURN 30213

MORRISON,WILLIAM N. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
MORTON,WILLIAM J. 29 ACT U
3646 CHAMBLEE TUCKER RD., CHAMBLEE 30341
MOSLEY,H.G. 29 DE5 OBG
3514 NANCY CREEK RD., ATLANTA 30327
MOSTELLAR,MARVOUS E. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
MOYER,LEROY N. 29 ACT OBG
1175 PEACHTREE ST. NE, ATLANTA 30309
MUNNA,JOHN C. 29 ACT PL
3316 PIEDMONT RD. NE, ATLANTA 30305
MUNOZ,JUANA L. 29 ACT PD
1100 CLEVELAND AVE., EAST POINT 30344
MURPHY,MICHAEL V.,JR. 29 ACT I
21 8TH ST. NE, ATLANTA 30309
MURPHY,RALPH A.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
MURRAY,DOUGLAS R. 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
NAHMIAS,ANDRE J. 29 A PD
69 BUTLER ST. SE, ATLANTA 30303
NAPOLI,VICTOR M. 29 ACT PATH
80 BUTLER ST. SE, ATLANTA 30303
NASH,H. E.,SR. 29 DE5 FP
982 SIMPSON ST.,NW, ATLANTA 30314
NASSAR,G. F. 29 ACT OBG
2739 FELTON DR., EAST POINT 30344
NEELD,JOHN B. 29 ACT ANES
2620 MEADOWLAWN DR., MARIETTA 30062
NEELY,F. LEVERING 29 ACT I
35 COLLIER RD.,NW, ATL 30309
NEWSOM,NEAL H. 29 ACT OBG
2045 PEACHTREE RD. NE, ATLANTA 30309
NEWTON,Z. B.,III 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
NICHOLAS,EDMUND M. 29 ACT U
490 PEACHTREE ST.,NE,STE.141, ATLANTA 30308
NICHOLS,JOSEPH J. 29 ACT PR
490 PEACHTREE ST. NE, ATLANTA 30308
NICKERSON,JOHN F. 29 ACT PATH
35 LINDEN AVE. NE, ATLANTA 30308
NICOLSON,WM. P.,III 29 ACT U
35 COLLIER RD. NW, ATLANTA 30309
NILES,GEORGE A.,JR. 29 ACT OBG
1938 PEACHTREE RD. NW, ATLANTA 30309
NINCIC,ALEXANDER 29 ACT U
401 PECHTREE ST.,NE,411, ATLANTA 30308
NINO,HOMERO F. 29 S R
P. O. BOX 33325, DECATUR 30033
NIPPERT,PHILIP H. 29 ACT D
478 PEACHTREE ST. NE, ATLANTA 30308
NOBLE,CARL W. 29 A SU
1054 N. VIRGINIA AVE.,NE, ATLANTA 30306
NOLAN,THOMAS R. 29 ACT SU
2788 BAYARD ST., EAST POINT 30344
NORTH,ALVIN W. 29 ACT OPH
575 W. PEACHTREE ST. NE, ATLANTA 30308
NORWOOD,WM. F. 29 ACT PD
3158 MAPLE DR. NE, ATLANTA 30305
NUGENT,JEFFREY T. 29 ACT OR
1938 PEACHTREE RD NW #705, ATLANTA 30309
NUNEZ,WILLIAM D. 29 ACT ANES
2760-B FELTON DR., EAST POINT 30344
NUTTER,DONALD O. 29 A I
69 BUTLER ST. SE, ATLANTA 30303
OBRIEN,DAVID P. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
OBRIEN,MARK S. 29 ACT NS
1365 CLIFTON RD. NE, ATLANTA 30322
OLANSKY,MARIAN F. 29 ACT PD
EMORY UNIVERSITY CLINIC, ATLANTA 30322
OLANSKY,SIDNEY 29 ACT D
EMORY UNIV. CLINIC, ATLANTA 30322
ONEAL,BUFORD L. 29 ACT OALR
478 PEACHTREE ST. NE, ATLANTA 30308
ORTEGA,HERNANDO JOSE 29 ACT SU
2958 RAINBOW DR., DECATUR 30034
OSBORNE,ELTON S.,JR. 29 ACT I
47 TRINITY AVE. SW, ATLANTA 30334
OTIS,JOHN B. 29 ACT PATH
340 BOULEVARD NE, ATLANTA 30312
OVERTON,JOHN W.,JR. 29 ACT EM
747 STONEVIEW CT. , MARIETTA 30062
PALAY,BERNARD H. 29 ACT I
1175 PEACHTREE ST. NE, ATLANTA 30309
PALMER,E. CAPERS,JR. 29 ACT PATH
1439 EMORY RD., ATLANTA 30306
PALMER,JAMES D. 29 ACT I
970 HUNTER STREET SW, ATLANTA 30314
PARNELL,R. PARKS,JR. 29 ACT FP
OAKDALE CLINIC, SMYRNA 30080
PARROTT,THOMAS S. 29 ACT U
137 DYSON DR.,NE, ATLANTA 30307
PARUNGAO,R. L. 29 ACT SU
1235 SALEN GATEWAY, CONYERS 30207
PATTERSON,JOS. H. 29 ACT PD
1405 CLIFTON RD. NE, ATLANTA 30333
PATTERSON,SCOTT 29 ACT P
811 JUNIPER ST. NE, ATLANTA 30308
PAULLIN,WM. L.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
PAYNE,NETTLETON S. 29 ACT N
1365 CLIFTON RD. NE, ATLANTA 30322
PAYNE,PETER M. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PEACOCK,LAMAR B. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
PEACOCKE,IVAN L. 29 ACT PATH
35 LINDEN AVE. NE, ATLANTA 30322
PEARCE,T. ELDER,JR. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PEEK,STANLEY L.,JR 29 ACT SU
1935 HOWELL MILL RD.,NW, ATLANTA 30318
PENDERGRAST,WM. J. 29 ACT SU
478 PTREE ST., NE, ATLANTA 30308
PENNINGTON,E. EARL 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PENTECOST,MARK P. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
PER-LEE,JOHN H. 29 ACT ALR
EMORY UNIV. CLINIC, ATLANTA 30322
PERDUE,GARLAND D.,JR. 29 ACT SU
EMORY UNIVERSITY CLINIC, ATLANTA 30322
PEREZ,A. R. 29 ACT SU
1311 CLEVELAND AVE., EAST POINT 30344
PERKINS,J. MORRIS 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
PERKINSON,NEIL G. 29 ACT SU
384 PEACHTREE ST. NE, ATLANTA 30308
PERLING,DAVIS S. 29 ACT I
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
PESZCZYNSKI,MIECZYSLAW 29 DE1 PM
80 BUTLER ST. SE, ATLANTA 30303
PETERS,MARGARET P. 29 S ANES
1670 CLAIRMONT RD. NE, ATLANTA 30329
PETRIE,LESTER M. 29 DE1 PH
304 WILTON DR., DECATUR 30030
PHILLIPS,CHARLES D. 29 ACT OR
607 HOLCOMB BRIDGE RD., ROSWELL 30075
PHILLIPS,THOMAS W. 29 ACT R
25 PRESCOTT ST., ATLANTA 30308
PHRYDAS,IRENE A. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
PIEROTTI,JULIUS V. 29 DE1 FP
2407 E. CLUB DR. NE, ATLANTA 30319
PIRKLE,CECIL H. 29 ACT SU
1311 CLEVELAND AVE., EAST POINT 30344
PITTMAN,FRANK S.,III 29 ACT P
960 JOHNSON FERRY RD. NE, ATLANTA 30342
PLAUTH,WILLIAM H.,JR. 29 ACT PDC
1365 CLIFTON RD. NE, ATLANTA 30322
POLIAKOFF,SAMUEL R. 29 ACT OBG
3290 HOWELL MILL RD,NW,321, ATLANTA 30327
POLITSOS,MICHAEL J. 29 ACT SU
35 LINDEN AVE. NE, ATLANTA 30308
POLLARD,ZANE F. 29 ACT OPH
575 W. PTREE ST. NE, ATLANTA 30308
PONCE DE LEON,A. I. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329

POOLE,ROBERT NEIL 29 ACT PD
5675 PTREE-DUNWOODY, ATLANTA 30342
PORTER,MAC W. 29 ACT FP
4575 N. SHALLOWFORD RD., ATLANTA 30341
PORTH,EDNA S. 29 ACT FP
3130 MAPLE DR. NE, ATLANTA 30305
POU,LEO H.,JR. 29 ACT ANES
2760 FELTON DR., EAST POINT 30344
POUND,EDWIN C.,JR. 29 ACT PL
35 COLLIER RD. NW, ATLANTA 30309
PREEDY,JOHN R. K. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
PRICE,NORMA A. 29 ACT I
5675 P'TREE-DNWDY RD,NE, ATLANTA 30342
PRUCE,ARTHUR 29 DE1 PM
384 PEACHTREE ST.,NE, ATLANTA 30308
PRUCE,MARTA 29 ACT P
10 CARLTON DR. NW, ATLANTA 30342
PUGH,JAMES W. 29 ACT FP
461 KING ARNOLD ST., HAPEVILLE 30354
QUARTERMAN,KEITH A. JR. 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
QUINN,FRANCIS B.,JR. 29 ACT OALR
144 PONCE DE LEON AVE. NE, ATLANTA 30308
QUINONES,PEDRO P. 29 A
99 BUTLER ST. SE, ATLANTA 30303
RAIFORD,MORGAN B. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
RAMOS,HAROLD S. 29 ACT I
35 LINDEN AVE. NE, ATLANTA 30308
RAND,EDGAR O. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
RANKIN,JOSEPH L. 29 ACT D
384 PEACHTREE ST. NE, ATLANTA 30308
RANKINE,C. A. N. 29 ACT FP
1224 FERNWOOD CIR., ATLANTA 30319
RASCOE,E. MARSTON 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
RASMUSSEN,E. P. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
RATCHFORD,WALTER J. 29 ACT OBG
1938 P'TREE RD,NW,408, ATLANTA 30309
RAVRY,MARIO J.R. 29 ACT GE
478 PEACHTREE ST.,NE, ATLANTA 30308
RAY,DERRELL W. 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
RAYEL,PETER A. 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
RAYLE,ALBERT A.,JR. 29 ACT R
490 PEACHTREE ST. NE, ATLANTA 30308
READ,BEN S. 29 R G
390 BLACKLAND RD,NW, ATLANTA 30342
READ,JOS. C. 29 DE5 SU
3970 VERMONT RD. NE, ATLANTA 30319
REDD,BRYAN L.,JR. 29 ACT R
401 PEACHTREE ST. NE, ATLANTA 30308
REDD,STEPHEN S. 29 ACT PD
2760 FELTON DR., EAST POINT 30344
REED,EDGAR A. 29 S I

REES,BRIGITTA A. 29 ACT N
80 BUTLER ST.,SE, ATLANTA 30303
REEVES,MARTIN M. 29 ACT ANES
485 N. HARBOR DR., ATLANTA 30328
REEVES,W. HARRISON 29 ACT I
478 PEACHTREE STREET NE, ATLANTA 30308
REHERT,GERALD M. 29 ACT OBG
490 PEACHTREE ST, #132-B, ATLANTA 30309
REICH,GEORGE A. 29 S PH
PEACHTREE 7TH BLDG., ATLANTA 30323
REID,WM. A. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
REISH,MARTIN L. 29 ACT PD
4536 CHAMBLEE-DUNWOODY RD., CHAMBLEE 30341
REISMAN,EDWARD D. 29 ACT SU
25 PRESCOTT ST, ATLANTA 30308
REITT,J. PETER 29 ACT NS
100 COLONY SQUARE, ATLANTA 30361
REYNAUD,L. F. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310
REYNAUD,VIRGINIA G. 29 ACT PD
1278 GORDON ST. S. W., ATLANTA 30310
REYNOLDS,J. S. 29 ACT FP
553 MOBILE AVE. SW, ATLANTA 30315
RICE,KEITH C. 29 DE5 SU
RT. 1, CLAYTON 30525
RICHARDSON,A. C.,JR. 29 ACT OBG
710 PEACHTREE ST. NE, ATLANTA 30308
RICHARDSON,HOWARD D. 29 ACT NS
340 BOULEVARD NE, ATLANTA 30312
RICHARDSON,STERLING H. 29 ACT SU
490 P'TREE ST,NE,STE. 356-B, ATLANTA 30308
RICHMAN,GARY O. 29 ACT OPH
3316 PIEDMONT RD. NE, ATLANTA 30305
RICHMOND,LEA 29 ACT SU
6500 VERNON WOODS DR., ATLANTA 30328
RICKS,HENRY C.,JR. 29 ACT P
415 E. PACES FERRY RD. NE, ATLANTA 30305
RICKS,ROBERT L. 29 ACT OBG
565 FAIR ST. SW, ATLANTA 30314
RIDLEY,HARRY W. 29 DE5 FP
SEA ISLAND 31561
RIDLEY,JOHN H. 29 ACT G
35 COLLIER RD. NW, ATLANTA 30309
RIESER,CHARLES 29 DE5 U
3777 PACES FERRY RD. NW, ATLANTA 30327
RIESER,JOHN C. 29 ACT OPH
1365 CLIFTON RD. NE, ATLANTA 30322
RIST,KARL H. 29 S R
2440 EDGEWATER DR,SW, ATLANTA 30311
RITCHEY,STERLING J. 29 ACT OR
EMORY UNIV. CLINIC, ATLANTA 30322
RIVERS,SHIRLEY L. 29 A I
1925 MONROE DR. NE, ATLANTA 30324
RIVKIN,LAWRENCE M. 29 ACT TS
1220 PACES FOREST DR. NW, ATL 30327
ROACH,GEORGE S.,JR. 29 ACT ALR
144 PONCE DE LEON AVE. N.E., ATLANTA 30308
ROBINSON,ALBERT H. 29 A PH
3060 PHARR COURT NW, ATLANTA 30305
ROBINSON,PAUL H. 29 ACT C
1365 CLIFTON RD. NE, ATLANTA 30322
ROBINSON,RALPH L. 29 ACT PD
3158 MAPLE DR. NE, ATLANTA 30305
ROBITSCHER,JONAS 29 ACT P
EMORY UNIV. LAW SCHOOL, ATLANTA 30322
RODRIGUEZ,A. P. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
RODRIGUEZ,FERNANDO 29 S I
P. O. BOX 33115, DECATUR 30033
RODRIQUEZ,J. I. 29 ACT I
3307 PRINCE GEORGE ST., EAST POINT 30344
RODZEWICA,PAUL J. 29 ACT I
400 COLONY SQUARE #1605, ATLANTA 30361
ROGERS,CHARLES G. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
ROGERS,HARRISON L.,JR. 29 ACT SU
1938 PEACHTREE RD NW #601, ATLANTA 30309
ROGERS,J. HARRY 29 DE5 SU
490 PEACHTREE ST. NE, ATLANTA 30308
ROOKER,DONALD W. 29 ACT ALR
960 JOHNSON FERRY RD.,NE, ATLANTA 30342
ROSE,FRED D. 29 ACT I
272 BOULEVARD,NE, ATLANTA 30312
ROSEN,ARNOLD J. 29 ACT SU
1916 PATTERSON ST.,300, NASHVILLE,TN. 37203
ROSENBAUM,BARRY J. 29 ACT NE
1365 CLIFTON RD NE, ATLANTA 30322
ROSSI,ALBERTO E. 29 ACT OBG
1100 CLEVELAND AVE.,201, EAST POINT 30344
ROTHENBERG,MARVIN B. 29 ACT OR
6500 VERNON WOODS DR. NE, ATL. 30328
ROTTERSMAN,WILLIAM 29 ACT P
3280 HOWELL MILL RD. N. W., ATLANTA 30327
ROUGHTON,RALPH E.,JR. 29 ACT P
1175 PEACHTREE ST. NE, ATLANTA 30309
ROUTON,JAMES L. 29 ACT ANES
705 JUNIPER ST. NE, ATLANTA 30308
ROWE,THOMAS S. 29 ACT OPH
490 PEACHTREE ST.,NE, ATLANTA 30308

RUBENSTEIN,ARNOLD B. 29 ACT U
2788 BAYARD ST., EAST POINT 30344
RUDDER,FRED F. 29 DE5 SU

RUDER,ERNST M. 29 ACT R
12411 KING'S LAKE DR., RESTON,VA 22091
RUSCA,JOHN A. 29 ACT PL
5675 PEACHTREE DNWDY RD, ATLANTA 30328
RUSHIN,C. E. 29 DE5 SU
478 PEACHTREE STREET NE, ATLANTA 30308
RUSSELL,DAVID A. 29 ACT FP
340 BOULEVARD NE, ATLANTA 30312
RUSSELL,E. K. 29 ACT I
600 W. PEACHTREE ST.,NE, ATLANTA 30308
RUSSELL,R. JAMES 29 ACT PL
3250 HOWELL MILL RD. NW, ATLANTA 30327
RUTLEDGE,BEN A. 29 DE1 OR
2348 ECHO CLIFF CT. NE, ATLANTA 30345
SAFFAN,B. D. 29 ACT I
401 PEACHTREE ST. N. E., ATLANTA 30308
SAKER,A. F. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30341
SALAM,ATEF A. 29 ACT SU
69 BUTLER ST. SE, ATLANTA 30303
SALE,WALTER T. 29 ACT R
35 COLLIER RD. NW, ATLANTA 30309
SALTER,PAUL P. III 29 A SU
3131 LAVENTURE DR., CHAMBLEE 30341
SAMMONS,EDWARD E. 29 ACT ANES
EMORY UNIV. HOSP., ATLANTA 30322
SANCHEZ,FRED H. 29 A SU
1422 OAK CT NE, ATLANTA 30319
SANDERS,C. VERNON 29 ACT I
6500 VERNON WOODS DR. NE, ATLANTA 30328
SANDERS,STEVEN L. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
SANDISON,J. CALVIN 29 DE5 OR

SARGENT,CARLTON W. 29 A PH
618 PONCE DE LEON AVE. NE, ATLANTA 30308
SATCHER,MILTON B.,JR. 29 ACT OR
2788 BAYARD ST., EAST POINT 30344
SCHATTEN,WM. E. 29 ACT PL
3280 HOWELL MILL RD NW #11, ATLANTA 30327
SCHEIDT,KENNETH A. 29 ACT
35 LINDEN AVE,NE, ATLANTA 30308
SCHELLACK,J. K. 29 ACT SU
490 PEACHTREE ST. NE, ATLANTA 30308
SCHERMERHORN,THOMAS J. 29 ACT OPH
705 JUNIPER ST. NE, ATLANTA 30308
SCHLANT,ROBERT C. 29 ACT I
69 BUTLER ST. SE, ATLANTA 30303
SCHLOSSBERG,MICHAEL 29 ACT OBG
2788 BAYARD ST., EAST POINT 30344
SCHMITT,ELBERT W.,JR. 29 ACT OR
1365 CLIFTON RD. NE, ATLANTA 30322
SCHOENBUCHER,ALBERT K. 29 A OBG
47 TRINITY AVE. SW, ATLANTA 30334
SCHRODER,J. SPALDING 29 ACT I
1365 CLIFTON RD,NE, ATLANTA 30322
SCHWARTZ,JAMES F. 29 ACT PD
69 BUTLER ST. SE, ATLANTA 30303
SCHWARTZ,SANFORD H. 29 ACT I
4536 CHAMBLEE DUNWOODY RD., CHAMBLEE 30341
SCHWARZMANN,STEPHEN W. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
SCOTT,CHARLES JR. 29 ACT U
340 BLVD.,NE, ATLANTA 30303
SCOTT,LEGH R. 29 ACT I
3312 PIEDMONT RD. NE, ATLANTA 30305
SCOTT,THOMAS P.,JR. 29 ACT PD
1311 CLEVELAND AVE., EAST POINT 30344
SCOTT,WILLIAM M.W. 29 ACT P
2151 PEACHFORD ROAD, ATLANTA 30341
SEALEY,ROMERO M. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SEAVEY,PAUL W. 29 ACT I
1365 CLIFTON RD. NE, ATLANTA 30322
SELLERS,T. F. 29 DE5
STATE DEPT. OF PUB. HEALTH, ATLANTA 30334
SELMONOSKY,CARLOS A. 29 ACT TS
1678 MULKEY RD., AUSTELL 30001
SELVEY,HENRY A. 29 ACT P
6363 ROSWELL RD. NE, ATLANTA 30328
SERBES,YILMAZ A. 29 ACT OR
5583 GORDON RD., MABLETON 30059
SESSIONS,HOWARD K. 29 A PH
P. O. BOX 781, SUMNER 31789
SHACKELFORD,HUGH W. 29 ACT R
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SHAMA,ZOUTHEIR A. 29 ACT SU
2931 APPLING DR., CHAMBLEE 30341
SHANKS,JAMES Z. 29 ACT I
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
SHANTHA,TOTADA R. 29 ACT ANES
384 PEACHTREE ST. NE, ATLANTA 30308
SHEA,P. C.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
SHEAHAN,ROBERT C. 29 A ACM
1800 PEACHTREE ST. NE, ATLANTA 30309
SHEHEE,WALTER H. 29 ACT P
1338 CLEVELAND AVE., EAST POINT 30344
SHEPARD,DUNCAN 29 ACT SU
3312 PIEDMONT RD. NE, ATLANTA 30305
SHESSEL,HERBERT L. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
SHINALL,ROBERT P. 29 DE1 FP
927 ARTWOOD RD. NE, ATLANTA 30307
SHIVERS,OLIN C. 29 ACT PD
47 PEACHTREE PKWY., NE, ATLANTA 30309
SHMERLING,SANFORD A. 29 ACT I
3316 PIEDMONT RD. NE, ATLANTA 30305
SHORTER,HENRY F.,JR. 29 ACT FP
960 HUNTER ST. SW, ATLANTA 30314
SHUFORD,WADE H. 29 A R
80 BUTLER ST. SE, ATLANTA 30303
SHULER,ROBERT K. 29 ACT PD
3158 MAPLE DR.,NE, ATLANTA 30305
SHULMAN,MICHAEL G. 29 ACT I
3200 HOWELL MILL RD, NW, ATLANTA 30327
SIEGAL,JEROME H. 29 DE2 I
215 E.68TH ST.,APT 10-M, NEW YORK,NY 10021
SIEVERT,ALAN J. 29 ACT PD
1100 CLEVELAND AVE., EAST POINT 30344
SIGMAN,CHENEY C. 29 ACT AL
3393 PEACHTREE RD. NE, ATLANTA 30326
SILLER,EVERARD J. 29 ACT N
MONASTERY OF THE HOLY SPIRIT, CONYER 30207
SILVERMAN,BARRY D. 29 A C
1000 JOHNSON FRY. RD. NE, ATLANTA 30342
SILVERMAN,MARK E. 29 A I
1968 PEACHTREE RD.,NW, ATLANTA 30309
SILVERMAN,STUART H. 29 ACT OPH
5040 SNAPFINGER WOOD RD., DECATUR 30035
SILVERSTEIN,CHARLES M. 29 ACT R

SIMMONS,WILLIAM C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
SIMONE,GREGORY L. 29 A
80 BUTLER ST. SE, ATLANTA 30303
SIMS,S.E. 29 ACT SU
100 EDGEWOOD AVE, SE, ATLANTA 30303
SIMS,S.E. 29 ACT SU
100 EDGEWOOD AVE SE #1605, ATLANTA 30303
SKANDALAKIS,JOHN E. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
SKARDASIS,GEORGE M. 29 ACT VS
25 PRESCOTT ST. NE, ATLANTA 30308
SKELTON,W. DOUGLAS 29 ACT P
47 TRINITY AVE. SW, ATLANTA 30334
SKOBBA,JOSEPH S. 29 A P
2386 DELLWOOD DR. NW, ATLANTA 30305
SKORAPA,MARY Z. 29 ACT PM
VA HOSPITAL, TOGAS,MAINE 04330
SLADE,JOHN DE R. 29 ACT I
768 JUNIPER ST. NE, ATLANTA 30308
SLOAN,W. P. 29 DE5 I
340 BLVD. NE, ATLANTA 30312
SLOAN,W. P.,JR. 29 ACT I
340 BLVD. N. E., ATLANTA 30312

SLUTSKY,MORTON 29 ACT PL
275 CARPENTER DR. NW, ATLANTA 30328
SMILEY,DAVID T. 29 ACT ALR
3316 PIEDMONT RD. NE, ATLANTA 30305
SMILEY,RUSSELL B.,JR. 29 ACT C
JOAN GLANCY MEMORIAL HOSPITAL, DULUTH 30136
SMITH,ARTHUR A. 29 ACT OBG
401 PEACHTREE ST. NE, ATLANTA 30308
SMITH,CARTER 29 DE5 I
35 COLLIER RD. NW, ATLANTA 30309
SMITH,CARTER,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
SMITH,CHAS. W. 29 ACT OBG
57 SIXTH ST. NE, ATLANTA 30308
SMITH,E. G.,JR. 29 ACT R
35 LINDEN AVE. NE, ATLANTA 30308
SMITH,JOEL P.,JR. 29 ACT OALR
573 W. PEACHTREE ST. NE, ATLANTA 30308
SMITH,RICHARD A. 29 ACT NS
35 COLLIER RD. NW, ATLANTA 30309
SMITH,RICHARD B. 29 ACT PD
5675 PTREE-DUNWOODY RD. NE, ATLANTA 30342
SMITH,ROBERT B.,III 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
SMITH,ROBERT W. 29 ACT I
478 PEACHTREE ST. NE, ATLANTA 30308
SMITH,WILLIAM A.,JR. 29 ACT OPH
960 JOHNSON FERRY RD. NE, ATLANTA 30342
SMITH,WILLIAM S. 29 ACT OTO
490 PEACHTREE ST #347-B, ATLANTA 30308
SMITH,WM. A. 29 DE5 N
35 COLLIER RD. NW, ATLANTA 30309
SNITZER,JOSEPH A.,III 29 ACT PD
3162 PIEDMONT RD. NE, ATLANTA 30305
SODER,PARRY D. 29 ACT R
265 IVY ST. NE, ATLANTA 30303
SOLODAR,SEYMOUR O. 29 DE4 P
OAKLAND NAVAL HOSPITAL, OAKLAND,CAL. 94627
SONES,PETER J. 29 ACT R
1365 CLIFTON RD. NE, ATLANTA 30322
SORACCO,GERARDO J. 29 ACT TS
1311 CLEVELAND AVE., EAST POINT 30344
SORIANO,MARIA J. R. 29 ACT PD
35 COLLIER RD. NW, ATLANTA 30309
SORSDAHL,OLIVER A. 29 ACT R
300 BOULEVARD NE, ATLANTA 30312
SOWELL,DAVID S. 29 ACT FP
2797 CAMPBELLTON RD., ATLANTA 30311
SPANIER,JACOB A. 29 ACT OBG
340 BOULEVARD NE, ATLANTA 30312
SPEARMAN,WILLIAM B. 29 ACT I
1201 PEACHTREE ST., ATLANTA 30361
SPENCER,WM. C.,III 29 ACT R
35 LINDEN AVE., ATLANTA 30308
ST. LOUIS,JOSEPH A.,JR. 29 ACT OPH
275 CARPENTER DR., ATLANTA 30328
STAATS,ETHAN F. 29 ACT OALR
35 COLLIER RD. NW, ATLANTA 30309
STACY,L. DAVID 29 ACT PATH
4575 N. SHALLOWFORD RD., CHAMBLEE 30341
STAPLETON,SIDNEY L.,JR. 29 ACT VS
914 CLIFTON RD.,NE, ATLANTA 30322
STAPLETON,SIDNEY L,JR 29 ACT VS

STATON,TED L. 29 ACT U
340 BOULEVARD NE, ATLANTA 30312
STEADMAN,HENRY E. 29 ACT SU
340 BOULEVARD NE, ATLANTA 30312
STEIN,IGNATIUS J. 29 ACT SU
2391 SEWELL RD. SW, ATLANTA 30311
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1285 PEACHTREE ST.,NE, ATLANTA 30309
STEINHAUS,JOHN E. 29 ACT ANES
1365 CLIFTON RD. NE, ATLANTA 30322
STEPHENSON,ROBERT H. 29 ACT SU
3250 HOWELL MILL RD. NW, ATLANTA 30327
STEWART,CALVIN B. 29 DE5 SU
478 PEACHTREE ST. NE, ATLANTA 30308
STIVERS,ROBERT R. 29 ACT PATH
50 COCA COLA PLACE SE, ATLANTA 30303
STOKES,J. JACK 29 ACT OPH
478 PEACHTREE ST. NE, ATLANTA 30308
STONE,CHARLES F.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
STONE,H. HARLAN 29 ACT SU
1365 CLIFTON RD. NE, ATLANTA 30322
STONE,WILLIAM D. 29 ACT
573 W. PEACHTREE ST. NE, ATLANTA 30303
STONER,CYRUS H. 29 DE5 OPH
340 BOULEVARD NE, ATLANTA 30312
STRICKLER,C. W.,JR. 29 DE1 I
215 TOWNSEND PL. NW, ATLANTA 30327
STROUP,DAVID G. 29 ACT OBG
1311 E. CLEVELAND AVE., EAST POINT 30344
STUART,CARLOS A. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
STUART,WILLIAM H. 29 ACT I
25 PRESCOTT ST., ATLANTA 30308
STURM,HIRAM MAXWELL 29 ACT D
401 PEACHTREE ST. NE, ATLANTA 30308
SUIT,JAMES I. 29 I&R OPH
80 BUTLER ST.,SW, ATLANTA 30303
SULLIVAN,CARY E. 29 ACT PD
2555 CUMBERLAND PKWY, ATLANTA 30339
SULLIVAN,LOUIS W. 29 ACT I
223 CHESTNUT ST.,SW, ATLANTA 30314
SUNG,YUNG-FONG 29 ACT ANES
ANES DEPT, EMORY HOSP, ATLANTA 30322
SWANN,JULIAN W. 29 ACT D
490 PEACHTREE ST. NE, ATLANTA 30308
SWANSON,HOMER 29 R NS
1938 PEACHTREE RD. NW, ATLANTA 30309
SWISTERSKI,K. PETER 29 ACT ANES
20 LINDEN AVE. NE, ATLANTA 30308
SYMBAS,PETER 29 ACT TS
69 BUTLER ST. SE, ATLANTA 30303
TAIT,C. DOWNING,JR. 29 ACT P
820 DOUGLAS RD. NE, ATLANTA 30342
TANNER,JAMES C.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
TARANTO,ALAN I. 29 ACT I
5675 P'TREE-DNWDY RD, 510, ATLANTA 30342
TARANTO,MORRIS B. 29 ACT FP
727 W. PEACHTREE STREET NE, ATLANTA 30308
TARCAN,YAVUZ A. 29 A I
80 BUTLER ST. SE, ATLANTA 30303
TAUBER,CHARLES P. 29 ACT P
415 E.PACES FERRY RD. NE, ATLANTA 30305
TAYLOR,DAVID M. 29 ACT I
340 BOULEVARD NE, ATLANTA 30312
TAYLOR,TERRY W. 29 ACT OPH
960 JOHNSON FERRY ROAD NE, ATLANTA 30342
TAYLOR,WILLIAM J. 29 ACT FP
2049 PERKERSON RD. SW, ATLANTA 30310
TEKIN,MAHIR 29 ACT ANES
3240 JETT FERRY CT. NE, DUNWOODY 30338
TEMPLES,POWELL M.,JR. 29 DE4 P
209 EERIE AVE, DECATUR 30033
TEPLIS,PAUL 29 ACT I
3250 HOWELL MILL RD. NW, ATLANTA 30327
TERRY,JULES S. 29 A OBG
47 TRINITY AVE., ATLANTA 30334
THEBAUT,BEN R. 29 ACT SU
960 JOHNSON FERRY RD,NE,405, ATLANTA 30342
THITARAM,SOMPHONG 29 ACT SU
2351 BOLTON RD,NW, ATLANTA 30318
THOMAS,KENNETH E. 29 ACT SU
1938 PEACHTREE RD. NW, ATLANTA 30309
THOMAS,WILLIAM K. 29 I&R OPH
80 BUTLER ST.,SE, ATLANTA 30303
THOMASON,W. L. 29 DE5 SU
1272 BREEZY LN. NE, ATLANTA 30329
THOMPSON,D. O. 29 DE5 FP
478 PEACHTREE ST. NE, ATLANTA 30308
THOMPSON,HUGH S.,JR. 29 ACT OR
1203 CLEVELAND AVE., EAST POINT 30344
THOMPSON,JOHN D. 29 ACT OBG
69 BUTLER ST., SE, ATLANTA 30303
THOMPSON,JOHN W. 29 DE1 PD
3814 VERMONT RD. NE, ATLANTA 30319

THOMPSON,WILLIAM R. 29 ACT OBG
1691 CANDLER ROAD, DECATUR 30032
THORNTON,NATHANIEL A. 29 ACT I
1201 PEACHTREE ST. NE, ATLANTA 30361
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400 COLONY SQUARE #1605, ATLANTA 30361
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3280 HOWELL MILL RD NW #307, ATLANTA 30327
THRONE,MARTIN L. 29 ACT I
3648 CHAMBLEE-TUCKER RD., CHAMBLEE 30340
THWAITE,WALTER G. 29 A OBG
69 BUTLER ST. SE, ATLANTA 30303
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1405 CLIFTON RD. NE, ATLANTA 30322
TIMBERLAKE,G. B. 29 ACT SU
133 CARNEGIE WAY NW, ATLANTA 30303
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35 COLLIER RD. NW, ATLANTA 30309
TINDALL,HARRY C. 29 ACT OPH
1938 PEACHTREE RD. NW, ATLANTA 30309
TODD,CHARLES E.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
TOMAS,TEOFILO 29 ACT OPH
490 PEACHTREE ST. NE, ATLANTA 30308
TOOLE,WM. NISBET 29 ACT U
6500 VERNON WOODS RD. NE, ATLANTA 30328
TOPOROFF,STUART J. 29 ACT I
265 IVY ST. NE, ATLANTA 30303
TORNOW,ABRAHAM M. 29 S GE
1670 CLAIRMONT RD. NE, DECATUR 30030
TUCKER,R. P. 29 ACT SU
1603 WARE AVE., EAST POINT 30344
TURCOTTE,MAURICE R. 29 ACT
P.O. BOX 768, EAST POINT 30344
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35 COLLIER RD. NW, ATLANTA 30309
TURNER,AUGUST B. 29 ACT SU
384 PEACHTREE ST. NE, ATLANTA 30308
TURNER,CORBETT H. 29 ACT P
EMORY UNIV. CLINIC, ATLANTA 30322
TURNER,JOHN S.,JR. 29 ACT OALR
1388 COUNCIL BLUFF DR.,NE, ATLANTA 30345
TURNER,JOHN W. 29 DE5 SU
384 PEACHTREE ST., ATLANTA 30308
TURRENTINE,PAUL E. 29 ACT OBG
35 COLLIER RD. NW, ATLANTA 30309
TUTSCH,WILBERT R. 29 ACT OR
1311 CLEVELAND AVE., EAST POINT 30344
TUTTLE,ELBERT P.,JR. 29 A I
69 BUTLER ST. SE, ATLANTA 30303
TYLER,RICHARD M. 29 ACT OR
2351 BOLTON RD. NE, ATLANTA 30318
UHL,LAWRENCE W. 29 ACT PD
6043 NAVAHO TR., MORROW 30260
ULLMAN,KARL H. 29 ACT I
1311 CLEVELAND AVE., EAST POINT 30344
UNDERWOOD,FRANK O. 29 ACT R
1968 PEACHTREE RD. NW, ATLANTA 30309
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98 CURRIER ST. NE, ATLANTA 30308
UPSHAW,CHARLES B.,JR. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
UPSON,E. T. 29 R SU
RT. 7, BOX 241, CUMMING 30130
VALDERRAMA,HUGO 29 ACT PATH
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VAN BUREN,E. 29 DE5 I
768 JUNIPER ST. NE, ATLANTA 30308
VAN BUREN,JAMES K. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
VAN DE WETERING,R. J. 29 ACT P
5675 PEACHTREE-DNWDY RD NW, ATLANTA 30342
VARNER,JOHN B. 29 ACT OBG
490 PEACHTREE ST. NE, ATLANTA 30308
VASCONEZ,LUIS O. 29 ACT PL
1365 CLIFTON RD., ATLANTA 30322
VEATCH,J. W.,JR. 29 ACT SU
25 PRESCOTT ST. NE, ATLANTA 30308
VELKOFF,ABRAHAM S. 29 ACT OBG
1175 PEACHTREE ST. NE, ATLANTA 30309
VENABLE,JOHN H. 29 A PH
2418 HOWELL MILL RD.,NW, ATLANTA 30318
VERLEY,KARL W. 29 ACT OBG
2945 STONE HOGAN RD. SW, ATLANTA 30331
VISINTINE,AAROLYN M. 29 A PD
69 BUTLER ST. SE, ATLANTA 30303
VITNER,SAUL 29 ACT OBG
275 CARPENTER DR. NE, ATLANTA 30328
VOHMAN,MANN DARIUS 29 ACT PATH
1968 PEACHTREE RD. NW, ATLANTA 30309
VOLJAVEC,BOZIDAR F. 29 ACT FP
1311 CLEVELAND AVE., EAST POINT 30344
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2788 BAYARD ST., EAST POINT 30344
WADSWORTH,GERALD E. 29 ACT OPH
478 PEACHTREE ST. NE, ATLANTA 30308
WAGGONER,DAVID C. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
WAITS,EDWARD JONES 29 ACT SU
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WALKER,HENRY K. 29 A I
80 BUTLER ST. SE, ATLANTA 30303
WALKER,JOHN R. 29 DE5 SU
922 W. PTREE ST., ATLANTA 30309
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2417 BERMUDA HILLS RD., COLUMBIA, SC 20204
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960 JOHNSON FERRY RD.,NE, ATLANTA 30342
WALTER,JONNE B. 29 A I
300 BOULEVARD NE, ATLANTA 30312
WALTON,KENNETH N. 29 ACT U
1365 CLIFTON RD. NE, ATLANTA 30322
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1670 CLAIRMONT RD. NE, ATLANTA 30329
WARD,M. TERRY 29 ACT EM

WARD,RICHARD S. 29 ACT P
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WARD,WM. C. 29 ACT SU
2292 FAIRBURN RD. SW, ATLANTA 30331
WARKENTIN,JOHN 29 ACT P
2905 PEACHTREE RD. NE, ATLANTA 30305
WARNER,CLINTON E. 29 ACT SU
319 W. LAKE AVE. NW, ATLANTA 30318
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35 COLLIER RD. NW, ATLANTA 30309
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1143 BANBURY CROSS, AVONDALE ESTATES 30002
WARREN,HOWELL R. 29 ACT P
1970 CLIFF VALLEY WAY NE, ATLANTA 30329
WARREN,W. C.,JR. 29 DE5 ALR
490 PEACHTREE ST. NE, ATLANTA 30308
WARREN,WALTER D. 29 ACT SU
1364 CLIFTON RD. NE, ATLANTA 30322
WASHBURN,LAWRENCE,JR. 29 ACT P
3400 PEACHTREE RD. NE, ATLANTA 30326
WASSERMAN,STANLEY B. 29 ACT PD
99 BUTLER ST,SE, ATLANTA 30303
WATERS,JAMES L.,JR. 29 ACT OBG
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WATERS,WM. C.,III 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
WATKINS,JAMES W.,JR. 29 ACT SU
P.O. BOX 314, RIVERDALE 30274
WATKINS,W. LORRAINE 29 ACT PD
315 BOULEVARD,NE, ATLANTA 30312
WATSON,DAVID T. 29 ACT I
35 COLLIER RD. NW, ATLANTA 30309
WATSON,FRANCIS M.,JR. 29 ACT OR
1938 PEACHTREE RD #603, ATLANTA 30309
WATTERS,JULIAN Q. 29 ACT PD
5675 PTREE-DUNWOODY RD. N.E., ATL 30342
WEAVER,WILLIAM T. 29 ACT TS
340 BOULEVARD NE, ATLANTA 30312
WEBSTER,ROBERT M. 29 ACT FP
2415 FAIRBURN RD. SW, ATLANTA 30331
WEBSTER,ROBERT M. 29 ACT FP
2888 BAYARD ST, EAST POINT 30344
WEENS,H. S. 29 ACT R
80 BUTLER ST. SE, ATLANTA 30303

WEINBERG,SEYMOUR PAUL 29 ACT OBG
384 PEACHTREE STREET NE, ATLANTA 30308
WEISS,HARVEY A. 29 ACT PL
6500 VERNON WOODS DR. NE, ATLANTA 30328
WELCH,ANDREW J. 29 A OR
300 BOULEVARD NE, ATLANTA 30312
WELLS,ROBERT E. 29 ACT OR
1938 PEACHTREE RD. NW, ATLANTA 30309
WENGER,JULIUS 29 S I
1670 CLAIRMONT RD. NE, ATLANTA 30329
WENGER,NANETTE K. 29 A
80 BUTLER ST. S. E., ATLANTA 30303
WEST,J. HERBERT 29 ACT I
960 JOHNSON FERRY RD. NE, ATLANTA 30342
WEST,ROBERT M. 29 ACT
1134 MAIN ST., FOREST PARK 30050
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3250 HOWELL MILL RD.,NW, ATLANTA 30327
WHIDDER,DESIDERIUS C. 29 ACT SU
490 PEACHTREE ST., ATLANTA 30308
WHIPPLE,ROBERT L.,III 29 ACT I
3280 HOWELL MILL RD NW #125, ATLANTA 30327
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1999 CLIFF VALLEY WAY NE, ATLANTA 30329
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35 COLLIER RD. NW, ATLANTA 30309
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340 BOULEVARD NE, ATLANTA 30312
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340 BOULEVARD NE, ATLANTA 30312
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353 PARKWAY DR. NE, ATLANTA 30312
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1000 JOHNSON FERRY RD. NE, ATLANTA 30305
WIEGAND,STEWART E. 29 ACT D
6500 VERNON WOODS DR., ATLANTA 30328
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490 PEACHTREE ST. NE, ATLANTA 30308
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490 PEACHTREE ST. NE, ATLANTA 30308
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275 FIFTH ST. NW, ATLANTA 30318
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3250 HOWELL MILL RD., ATLANTA 30327
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EMORY UNIV. CLINIC, ATLANTA 30322
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1275 CLEVELAND AVE., EAST POINT 30344
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2945 STONE HOGAN RD CONN SW, ATLANTA 30331
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710 PEACHTREE ST. NE, ATLANTA 30308
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WILLIAMS,RALPH CHESTER 29 A PH
2573 BIRCHWOOD DR. NE, ATLANTA 30305
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35 COLLIER RD. NW, ATLANTA 30309
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1365 CLIFTON RD. NE, ATLANTA 30322
WILSON,FRANK L.,JR. 29 ACT SU
35 COLLIER RD. NW, ATLANTA 30309
WILSON,J. S. 29 ACT I
490 PEACHTREE ST. NE, ATLANTA 30308
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315 BOULEVARD NE, ATLANTA 30312
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47 INTERLOCHEN DR. NE, ATLANTA 30305
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6500 VERNON WOODS DR. NE, ATLANTA 30328
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315 BOULEVARD NE #400, ATLANTA 30312
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41 NELSON ST., CARTERSVILLE 30120
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35 COLLIER RD. NW, ATLANTA 30309
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35 COLLIER RD. NW, ATLANTA 30309
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3312 PIEDMONT RD.,NE, ATLANTA 30305
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3764 BRIARCLIFF RD. NE, ATLANTA 30345
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923 CASTLE FALLS DR. NE, ATLANTA 30329
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33 PONCE DE LEON AVE. N.E., ATLANTA 30308
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1365 CLIFTON RD. NE, ATLANTA 30322
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6500 VERNON WOODS DR. NE, ATLANTA 30328
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35 COLLIER RD. NW, ATLANTA 30309
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490 PEACHTREE ST. NE, ATLANTA 30308
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35 COLLIER RD. NW, ATLANTA 30309
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3158 MAPLE DR #49, ATLANTA 30305
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150 ROBIN HOOD RD. NE, ATLANTA 30309
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2845 ENGLE RD.,NW, ATLANTA 30318
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384 PEACHTREE ST. NE, ATLANTA 30308
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35 COLLIER RD. NW, ATLANTA 30309
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353 PARKWAY DR. NE, ATLANTA 30312
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2687 OVERLOOK DR. NE, ATLANTA 30345
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1970 CLIFF VALLEY WAY NE, ATLANTA 30329
YU,FRANK 29 ACT ANES
159 FORREST AVE. NE, ATLANTA 30303
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EMORY HOSP, 1364 CLIFTON RD, ATLANTA 30322
ZAKI,SALEH A. 29 ACT PATH
50 COCA COLA PL. SE, ATLANTA 30303
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33 S.W. UPPER RIVERDLE RD., RIVERDLE 30274
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340 BOULEVARD NE, ATLANTA 30312
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5 RETREET PL., ST. SIMONS. ISL. 31522
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P.O. BOX 1258, BRUNSWICK 31520
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3011 KEMBLE, BRUNSWICK 31520
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2560 TARA LA., BRUNSWICK 31520

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3104 SHRINE RD., BRUNSWICK 31520
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3204 SHRINE RD., BRUNSWICK 31520
EGAN,RICHARD W. 30 ACT SU
2432 PARKWOOD DR., BRUNSWICK 31520
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3114 SHRINE RD., BRUNSWICK 31520
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2705 WILDWOOD DR., BRUNSWICK 31520
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2444 PARKWOOD DR., BRUNSWICK 31520
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2432 PARKWOOD DR., BRUNSWICK 31520
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3010 HAMPTON, BRUNSWICK 31520
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2850 WILDWOOD DR., BRUNSWICK 31520
GLUCKSMAN,MICHEL A. 30 ACT U
2705 WILDWOOD DR., BRUNSWICK 31520
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2444 PARKWOOD DR., BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31522
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2001 GLOUCESTER ST., BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31520
HIGHTOWER,JOHN A. 30 ACT I
4101 RIVERSIDE DR., BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31520
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2700 PARKWOOD DR., BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31520
JOSEY,JOHN S. 30 ACT OPH
3010 HAMPTON AVE., BRUNSWICK 31520
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403 G. STREET, BRUNSWICK 31520
LUPO,CARL W. 30 DE5 ALR
P. O. BOX 1057, ST. SIMONS ISL. 31522
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3010 HAMPTON AVE., BRUNSWICK 31520
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2601 PARKWOOD DR., BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31520
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3011 KEMBLE AVENUE, BRUNSWICK 31520
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3010 HAMPTON AVE., BRUNSWICK 31520
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OSTA,SALIM M. 30 ACT ON
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3010 HAMPTON AVE., BRUNSWICK 31520
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P. O. BOX 1333, BRUNSWICK 31521
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P. O. BOX 1003, BRUNSWICK 31520
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P.O. BOX 1219, BRUNSWICK 31520
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3204 SHRINE RD., BRUNSWICK 31520
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SMITH,JOHN M.,JR. 30 ACT I
P. O. BOX 1059, ST. SIMONS IS. 31522
SMITH,MILLEDGE GLENN 30 ACT FP
3012 SHRINE RD., BRUNSWICK 31520
SMITH,WILLIAM JACKSON 30 ACT ANES
P.O. BOX 1518, BRUNSWICK 31520
SNYDER,WILLARD A. 30 ACT
2700 PARKWOOD DR., BRUNSWICK 31520
SPANJER,RAYMOND F. 30 ACT FP
P.O. BOX 846, SEA ISLAND 31561
STRICKLAND,AVERY W. 30 ACT I
3010 HAMPTON AVE., BRUNSWICK 31520
TAYLOR,HOWARD P. 30 DE5 FP
COTTAGE 218, SEA ISLAND 31561
THAGARD,ROY FRANK 30 ACT PD
2601 PARKWOOD DRIVE, BRUNSWICK 31520
TUTEN,CARROLL 30 ACT OPH
3011 KEMBLE AVE., BRUNSWICK 31520
VALENTE,L. A. 30 ACT SU
1801 REYNOLDS STREET, BRUNSWICK 31520
VAN DYKE,PAUL B. 30 DE5 FP
P.O. DRAWER N, BRUNSWICK 31520
WADDELL,PEARL B. 30 R PD
1631 LAWTON LANE, LAKELAND, FLA 33803
WEISS,EDWARD A. 30 DE4 N
USAF HOSP BOX 7214, EGLIN AFB FL. 32542
WHEELER,GEO. B.,III 30 ACT OBG
3020 SHRINE RD., BRUNSWICK 31520
WILLIS,TOM V.,JR. 30 ACT SU
3010 HAMPTON AVE., BRUNSWICK 31520
WILSON,C. A.,JR. 30 ACT FP
P.O. BOX 1518, BRUNSWICK 31520

31—GORDON

BILLINGS,J. E. 31 DE1 FP
CALHOUN 30701
BISHOP,JOSEPH A. 31 ACT FP
103 S. RIVER ST., CALHOUN 30701
DALTON,WILLIAM E. 31 ACT FP
105 E. 40TH DR., CALHOUN 30701
HALL,W. D. 31 ACT SU
S. WALL ST., CALHOUN 30701
LANG,LEWIS R. 31 ACT FP
323 S. WALL ST., CALHOUN 30701
PURCELL,BILL 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
RABB,J. L. 31 ACT FP
MEDICAL ARTS CENTER, CALHOUN 30701
STEELE,BYRON HAROLD 31 ACT FP
FAIRMOUNT 30139
THOMPSON,WILLIAM R. 31 ACT
5000 SNAPFINGER WDS DR, DECATUR 30032
WALTER,R. D. 31 ACT FP
CALHOUN 30701

33—HABERSHAM
(Habersham, Towns)

GARRISON,D. H. 33 DE5 FP
CLARKESVILLE 30523
GARRISON,FLETCHER O. 33 ACT FP
912 WAYSIDE ST., CORNELIA 30531

HICKS,L. G.,JR. 33 ACT ANES
CLARKESVILLE 30523
HODGES,THOMAS L. 33 ACT I
WILDWOOD CIRCLE, CLARKESVILLE 30523
LUMSDEN,THOMAS N. 33 ACT FP
P. O. BOX 45, CLARKESVILLE 30523
NICHOLSON,GEORGE T. 33 ACT FP
ROUTE 1,BOX178AB, MT. AIRY 30563
ROBERTS,B. J. 33 A I
MED. DIR., DIST. 22, TOCCOA 30577
SWAIN,BRUCE 33 ACT FP
CLARKESVILLE 30523
THAKRAR,B.D. 33 ACT SU
BOX 696, DEMOREST 30535
THAKRAR,CHANDRAKA B. 33 ACT ANES
P.O. BOX 696, DEMOREST 30535
THAMES,FRANK M.,JR. 33 ACT FP
BOX 367, DEMOREST 30535
WALTER,AUSTIN J. 33 ACT FP
SAUTEE 30571
WATERS,LAMAR H. 33 ACT I
BOX 305, CLARKESVILLE 30523
WINDHAM,ADDIS D.,SR. 33 ACT FP
BOX 367, DEMOREST 30535

34—HALL
(Dawson, Hall, Lumpkin, White)

ACREE,JOHN W. 34 ACT FP
HIAWASSEE 30546
ADDISON,WINNIFRED A. 34 ACT OBG
1144 VINE ST. NE, GAINESVILLE 30501
AGRIN,ALFRED 34 A R
315 S. ENOTA DR., GAINESVILLE 30501
ALDAY,JAMES M.,JR. 34 ACT OR
650 BROAD ST. SE, GAINESVILLE 30501
ALLEN,CALVIN H.,JR. 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501
ANDERSON,ROBERT H.,JR 34 ACT SU
194 GOLD ST., GAINESVILLE 30501
BANKS,RAFE,JR. 34 ACT U
290 ENOTA DR. NE, GAINESVILLE 30501
BATES,JACK M. 34 ACT P
500 SPRING ST. NW, GAINESVILLE 30501
BLACK,WILEY S. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
BLACKSHEAR,STUART G. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
BLOODWORTH,AUGUSTUS F. 34 ACT I
1098 S. ENOTA NE, GAINESVILLE 30501
BRADLEY,CHARLES K. 34 ACT OPH
1128 VINE ST., GAINESVILLE 30501
BROWN,THOMAS D.,JR. 34 ACT OTO
304 ENOTA DR., GAINESVILLE 30501
BURNS,JAMES R.,JR. 34 ACT FP
700 S. ENOTA DR. NE, GAINESVILLE 30501
BURNS,JOHN KNOX,III 34 ACT OBG
1100 VINE STREET, GAINESVILLE 30501
BUTTS,JAMES A. 34 ACT I
1732 VALLEY RD. NE, GAINESVILLE 30501
DIXON,P.K. 34 ACT SU
1114 VINE ST. NE, GAINESVILLE 30501
DURISCH,LAWRENCE L. 34 ACT OTO
304 ENOTA DR., GAINESVILLE 30501
EARLEY,WILLIAM H. 34 A P
BOX 2395, GAINESVILLE 30501
ESTES,EDWARD E.,JR. 34 ACT U
290 ENOTA DRIVE NE, GAINESVILLE 30501
FERRELL,WM. C. 34 ACT R
HALL CO. HOSPITAL, GAINESVILLE 30501
FRENCH,JAMES B. 34 ACT OBG
1100 VINE ST., GAINESVILLE 30501
GARLAND,JOHN W.,III 34 ACT P
500 E. SPRING ST., GAINESVILLE 30501
GARNER,W. R. 34 DE5 I
RT. 12, BOX 163-1, GAINESVILLE 30501
GEIGER,C. LEONARD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501
GHENT,OLIVER T. 34 R R
HALL CO. HOSP., GAINESVILLE 30501
GILBERT,BEN P. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
GOWDER,GEORGE D.,JR. 34 ACT
P. O. BOX 726, BLAIRSVILLE 30512
GRANT,ROBERT 34 ACT OBG
174 PRIOR ST.,NE, GAINESVILLE 30501
HARDMAN,BILLY S. 34 ACT OBG
420 BROAD ST.,SE, GAINESVILLE 30501
HEATON,SAMUEL A.,JR. 34 A FP
LAURENS CO. HEALTH DEPT., DUBLIN 31021
HOPKINS,RALPH D. 34 ACT R
HALL CO. HOSP., GAINESVILLE 30501
JACKSON,BILLY JOE 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501
JAMES,FLOYD 34 ACT PATH
HALL COUNTY HOSP., GAINESVILLE 30501
JENNINGS,HENRY S.,JR. 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
JOHNSON,ALLYN C.,JR. 34 ACT I
429 E. SPRING STREET, GAINESVILLE 30501
JOHNSTON,JOSEPH F. 34 ACT ANES
689 ROBINHOOD TR., GAINESVILLE 30501
JOINER,HARTWELL 34 DE5 I
319 N. BRADFORD ST., GAINESVILLE 30501
JORDAN,TOMMY H. 34 ACT P
500 SPRING ST. NE, GAINESVILLE 30501
KEITH,THOMAS L. 34 ACT ANES
ANES ASSOC OF GAINESVL, GAINESVILLE 30501
KELLEY,CHARLES N. 34 ACT I
710 BROAD ST., GAINESVILLE 30501
KENIMER,BARRY K. 34 ACT ANES
HALL COUNTY HOSP., GAINESVILLE 30501
LANCASTER,HOMER H. 34 DE5 FP
1798 CLEVELAND RD., GAINESVILLE 30501
LANGSTON,WILLIAM T. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
LEE,EUNG M. 34 ACT I
743 SPRING ST.,NE, GAINESVILLE 30501
LEIGH,JAMES H.,JR. 34 ACT SU
194 GOLD ST., GAINSVILLE 30501
LITTLE,CHARLES H. 34 ACT OR
700 S. ENOTA DR. NE, GAINESVILLE 30501
LONG,HAROLD G. 34 ACT
P. O. BOX 186, DAHLONEGA 30533
LUKE,DANIEL R. 34 ACT FP
1144 VINE ST. NE, GAINESVILLE 30501
MARRINER,E. F. 34 ACT OCM
CHICOPEE MFG. CO., GAINESVILLE 30501
MARTIN,LEE A. 34 ACT U
290 S. ENOTA DR., GAINESVILLE 30501
MCALISTER,BRADWELL R. 34 ACT OR
650 BROAD ST. SE, GAINESVILLE 30501
MCCARVER,W. C.,JR. 34 ACT FP
200 PRIOR ST. SE, GAINESVILLE 30501
MCCRUM,B. A. 34 ACT OBG
420 E. BROAD ST., GAINESVILLE 30501
MORRIS,LARRY A. 34 ACT PD
650 BROAD ST. SE, GAINESVILLE 30501
MURRAY,HAMIL 34 ACT PATH
HALL COUNTY HOSPITAL, GAINESVILLE 30501
NEWMAN,HARVEY M. 34 ACT PD
650 BROAD ST. S.E., GAINESVILLE 30501
NICHOLSON,W. LANIER 34 ACT FP
HIAWASSEE 30546
PEACOCK,RAY LOWELL,JR. 34 ACT PD
274 ENOTA DR. NE, GAINESVILLE 30501
POOL,LELAND L. 34 ACT ANES
HALL CO. HOSPITAL, GAINESVILLE 30501
POOLE,SAMUEL O. 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
RABB,FORTE C. 34 ACT D
327 NORTHSIDE DR. NW, GAINESVILLE 30501
RAUCH,SAMUEL DEAN 34 ACT I
710 BROAD ST., GAINESVILLE 30501
REED,JOHN H.,JR. 34 ACT OPH
1128 VINE ST. NE, GAINESVILLE 30501

RICHARDSON,RUSSELL E. 34 ACT FP
HALL CO. HOSP., GAINESVILLE 30501
SMITH,MARTIN H. 34 ACT PD
274 ENOTA DR. NE, GAINESVILLE 30501
SPEAR,J. LOUIS 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501
STEPHENS,MARVIN R. 34 ACT ANES
HALL COUNTY HOSPITAL, GAINESVILLE 30501
STRIBLING,WARREN DICKEY 34 ACT I
710 BROAD ST. SE, GAINESVILLE 30501
STRITTMATTER,JAMES C. 34 ACT R
HALL COUNTY HOSP., GAINESVILLE 30501
STUCK,ROBERT G. 34 ACT OR
MEMORIAL DR., DALTON 30720
TETHER,ROBERT S. 34 ACT SU
194 GOLD ST. NE, GAINESVILLE 30501
THOMPSON,WILBUR J. 34 ACT OBG
1144 VINE ST. NE, GAINESVILLE 30501
VALENTINE,H. E.,JR. 34 ACT I
429 SPRING ST. SE, GAINESVILLE 30501
WALKER,C. J.,JR. 34 ACT FP
242 ENOTA DR. NE, GAINESVILLE 30501
WARD,EUGENE L. 34 ACT OALR
P. O. BOX 13, GAINESVILLE 30501
WATTS,JERALD L. 34 ACT OR
710 BROAD STREET, SE, GAINESVILLE 30501
WHITE,WILLIAM H.,JR. 34 ACT OBG
1100 VINE ST. NE, GAINESVILLE 30501
WHITWORTH,C. W. 34 ACT OALR
P. O. BOX 1159, GAINESVILLE 30501
WOODWARD,J. G. 34 A FP
DAHLONEGA 30533
WRIGHT,ASBURY D.,JR. 34 ACT D
327 NORTHSIDE DR. NW, GAINESVILLE 30501
WRIGHT,JAMES R. 34 ACT OPH
301 NORTHSIDE DR. NW, GAINESVILLE 30501

36—PEACHBELT
(Houston, Macon, Peach)

ADAMS,J. FRED 36 DE5 FP
MONTEZUMA 31063
ADAMS,THOMAS M. 36 ACT
MONTEZUMA 31063
ARNALL,JOHN ROBERT 36 ACT FP
PERRY 31069
BARROSO,CARLOS H. 36 ACT U
507A N. HOUSTON RD #1, WARNER ROBINS 31093
BEARD,CARL L. 36 ACT OBG
105 BRIARCLIFF, WARNER ROBINS 31093
BLUE,JACOB S. 36 S IND

BOHANAN,G. WAYNE 36 ACT R
HOUSTON CO. HOSP., WARNER ROBINS 31093
BROWN,ELBERT H. 36 ACT FP
212 HOSPITAL DR., WARNER ROBINS 31093
CARTER,ROBERT A. 36 ACT
212 HOSPITAL DR., WARNER ROBINS 31093
CRAWFORD,CARL L. 36 ACT FP
1410 WATSON RD., WARNER ROBINS 31093
DEAN,CHARLIE W. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030
DUKE,JOHN F.,III 36 ACT FP
BOX 131, FT. VALLEY 31030
ENGLISH,INMAN C. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
FUSSELL,DANIEL O. 36 ACT I
212 HOSPITAL DR., WARNER ROBINS 31093
GRANTHAM,V. J. 36 ACT FP
700 KNOXVILLE ST., FT. VALLEY 31030
HARVEY,DAVID N.,III 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
HENDRICK,A. G. 36 ACT FP
1100 SWIFT ST., PERRY 31069
HERNANDEZ,FERNANDO G. 36 ACT I
511-A N. HOUSTON RD., WARNER ROBINS 31093
HULSEY,W. G. 36 ACT
1115 MORNINGSIDE DR., PERRY 31069
IVEY,C. RAY,JR. 36 ACT FP
1554 WATSON BLVD., WARNER ROBINS 31093
LUCAS,WALLACE 36 ACT FP
613 E. DYKES ST., COCHRAN 31014
MANNING,JOHANN R. 36 ACT OBG
105 BRIARCLIFF RD., WARNER ROBINS 31093
MARSHALL,A. SMOAK 36 ACT SU
725 N MACON ST., FORT VALLEY 31030
MCEVER,V. W.,JR. 36 ACT SU
212 HOSPITAL DR., WARNER ROBINS 31093
MCFALL,VORIS F. 36 ACT SU
WESTVIEW DRS. BLDG., FORT VALLEY 31030
MELVIN,PERRY D. 36 ACT FP
124 HOSP. DR., WARNER ROBINS 31093
MESERVE,FRANCIS BRUCE 36 ACT
121 N. DAVIS DR., WARNER ROBINS 31093
MILES,MARILYNN L. 36 ACT PD
140-C HOSPITAL DR., WARNER ROBINS 31093
MORRIS,A. J. 36 ACT SU
MONTEZUMA 31063
NATHAN,DANIEL E. 36 ACT FP
FORT VALLEY 31030
PILCHER,B. LAMAR 36 ACT R
HOUSTON CT. HOSP., WARNER ROBINS 31093
RAGHU,G.V. 36 ACT OBG
07-B N. HOUSTON RD., WARNER ROBINS 31093
RAYNOR,LUTHER K.,JR. 36 ACT OBG
507 N. HOUSTON RD., WARNER ROBINS 31093
ROMITAM,EMIL 36 ACT OTO
1120 MORNINGSIDE DR, PERRY 31036
SALEHBHAI, MANSOOR, 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093
SANDERS,F. HUNT 36 ACT ANES
ROUTE 4, COCHRAN 31014
SCHARF,FORREST L. 36 ACT PATH
BOX 882, LAKELAND,FL. 33802
SEAY,E. FAXTON 36 ACT
BOX 208, FT. VALLEY 31030
SENG,BARRY S. 36 ACT FP
100 PICKETT CT., WARNER ROBINS 31093
SEVERS,RONALD G. 36 ACT SU
DOCTORS CLINIC, WARNER ROBINS 31093
SPEARS,WENTFORD A. 36 ACT OALR
212 HOSPITAL DR., WARNER ROBINS 31093
SPIVEY,JAMES W. 36 ACT OR
124 HOSPITAL DR., WARNER ROBINS 31093
STRICKLAND, W.E. 36 ACT
1120 MORNINGSIDE DR., PERRY 31069
TALBERT,WILLIAM G.,JR 36 DE5 FP
212 HOSPITAL DR., WARNER ROBINS 31093
VINSON,FRANK 36 DE5 FP
FORT VALLEY 31030
WEEMS,H. E.,JR. 36 ACT FP
PERRY 31069
WHITAKER, JAMES Q. 36 ACT PATH
HOUSTON COUNTY HOSP., WARNER ROBINS 31093
WYNNE,MORGAN D.,JR. 36 ACT PD
212 HOSPITAL DR., WARNER ROBINS 31093

37—JACKSON-BANKS

CRENSHAW,JOHN T. 37 ACT FP
P. O. BOX 219, JEFFERSON 30549
GRIFFETH,JOE L. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529
HOLLOWAY,EMORY W.,JR. 37 A FP
P. O. BOX 126, COMMERCE 30529
ROGERS,A. A. 37 DE5 FP
COMMERCE 30529
ROGERS,A.A.,JR. 37 ACT FP
COMMERCE 30529
SCOGGINS,P. T. 37 DE5 FP
COMMERCE 30529
SERGENT,PAUL M. 37 ACT FP
335 SOUTH BROAD ST, COMMERCE 30529

TURK,L. N.,JR. 37 ACT SU
P. O. BOX 52, HOMER 30547
VICKERY,S. A. 37 ACT FP
MEDICAL CENTER CLINIC, COMMERCE 30529

39—JEFFERSON

DUMAIS,ALCID F. 39 ACT SU
1067 PEACHTREE ST., LOUISVILLE 30434
ENCINAS, SENEN J. 39 ACT FP
P.O. BOX 151, LOUISVILLE 30434
FARRIS,JOHN J. 39 ACT
BARTOW 30413
PILCHER,JAMES W. 39 ACT I
512 W. 8TH ST., LOUISVILLE 30434
REVELL,WALTER J. 39 ACT
P.O. BOX 5, LOUISVILLE 30434
WILLIAMS,CHARLES ROY 39 ACT FP
WADLEY 30477
YUN,IN W. 39 ACT FP
809 ESTELLE ST., WRENS 30833

42—LAURENS
(Johnson, Laurens)

AQUILAR,JUAN J. 42 S SU
VA CENTER, DUBLIN 31021
AVERA,BERTRAM PRICE,JR. 42 S I
VA HOSPITAL, DUBLIN 31021
BELL,J. A.,JR. 42 ACT FP
DUBLIN MEDICAL ARTS CENTER, DUBLIN 31021
BRANTLEY,J. G. 42 DE5 FP
WRIGHTSVILLE 31096
BUSH,JAMES L. 42 S OALR
RT. 3,BOX 212A, DUBLIN 31021
CABRERA-CICERO,ORLANDO 42 S SU
VA CENTER, DUBLIN 31021
CAMPBELL,CLARENCE G.,JR 42 ACT R
LAURENS CO. HOSP., DUBLIN 31021
CARSWELL,NELSON S.,JR. 42 ACT PD
MEDICAL ARTS CENTER, DUBLIN 31021
CHUNG,SOONG PYO 42 ACT PATH
VA CENTER, DUBLIN 31021
COLEMAN,FRED J. 42 ACT SU
106 N. CHURCH ST., DUBLIN 31021
DODD,WILLIAM ASA 42 ACT FP
P.O. BOX 257, WRIGHTSVILLE 31096
DUPREE,J. T. 42 S SU
VA CENTER, DUBLIN 31021
FERNANDEZ,B. P. 42 ACT I
V. A. CENTER, DUBLIN 31021
FITZGERALD,EDMUND M.,JR. 42 S I
VA CENTER, DUBLIN 31021
FRANCO,JAIME 42 ACT PATH
LAURENS MEM. HOSP., DUBLIN 31021
GLOVER,RIDLEY M. 42 ACT R
LAURENS MEM. HOSP., DUBLIN 31021
GOODWIN,FRANKLIN H. 42 S I
V A CENTER, DUBLIN 31021
HENDRICKS,CHAS M.,JR. 42 S I
V A CENTER, DUBLIN 31021
HOLDEN,M. H. 42 ACT FP
VA CENTER, DUBLIN 31021
JOHNSON,OTTO B.,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
KAVURI,SURENDRANATH 42 ACT PD
112 ROWE ST., DUBLIN 31021
KIBLER,JAMES A. 42 ACT P
420 ACADEMY AVE., DUBLIN 31021
KIM,SOON OK 42 ACT
VA CENTER, DUBLIN 31021
KIRKLAND,JAMES J. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
LONGINO,GRADY E. 42 ACT I
VA CENTER, DUBLIN 31021
MADDRY,EDGAR L. 42 S ACM
VA CENTER, DUBLIN 31021
MORTON,JOHN B. 42 ACT I
V. A. CENTER, DUBLIN 31021
MULLIS,KENNETH L. 42 ACT FP
309 BELLEVUE AVE., DUBLIN 31021
ODANIEL,J. F. 42 R FP
107 ROWE ST., DUBLIN 31021
OLIVER,ROBERT W.,JR. 42 ACT SU
508 ACADEMY AVE., DUBLIN 31021
PRADA,OSCAR 42 ACT FP
112 ROWE ST., DUBLIN 31021
PRICE,QUENTIN 42 ACT FP
205 W. GAINES ST., DUBLIN 31021
PROCTOR,ROBERT F. 42 ACT I
VA CENTER, DUBLIN 31021
REEVES,SEAB E. A. 42 ACT ANES
219 WAVERLY DR., DUBLIN 31021
ROCHE,WM. PATRICK,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
ROWLAND,J. ROY,JR. 42 ACT FP
MEDICAL CENTER, DUBLIN 31021
SATHE,ANAND J. 42 ACT OBG
107 VERNON ST., DUBLIN 31021
SKINNER,JOHN J.,JR. 42 ACT I
606 ACADEMY AVE., DUBLIN 31021
SMITH,JAMES E. 42 ACT SU
508 ACADEMY AVE., DUBLIN 31021
SMITH,MALCOLM M. 42 R FP
SHAMROCK COURT APT., DUBLIN 31021
STAPLETON,JAMES W. 42 S OR
VA HOSPITAL, DUBLIN 31021
TANNER,GEO. E. 42 ACT SU
606 ACADEMY AVE., DUBLIN 31021
WATKINS,W. M. 42 ACT SU

44—McDUFFIE
(Columbia, McDuffie)

AVERITT,THOMAS E. 44 ACT FP
P. O. BOX 408, THOMSON 30824
LEMLEY,JOHN W. 44 ACT FP
DOCTORS BLDG., THOMSON 30824
LEROY,ALBERT G. 44 ACT FP
THOMSON 30824
MAXWELL,EDGAR J.,JR. 44 ACT SU
P.O. DR. 190, THOMSON 30824
MIDDLEBROOKS,T. W. 44 ACT FP
THOMSON 30824
VAUGHAN,WILLIAM L. 44 ACT SU
KNOX PLAZA, THOMSON 30824
WHALEY,MORGAN N. 44 ACT FP

WHALEY,MORGAN N. 44 ACT FP
312 HOSPITAL DRIVE, THOMSON 30824

45—MERIWETHER-HARRIS-TALBOT

BENNETT,ROBERT L. 45 ACT PM
THE FOUNDATION, WARM SPRINGS 31830
BENNETT,V. H. 45 DE5 FP
801 RIVERHILL DR., ATHENS 30601
CALVERT,WILSON C. 45 ACT I

CHAMBLESS,MIRIAM WALKER 45 ACT FP
HAMILTON 31811
CHAMBLESS,WILLIAM G. 45 ACT FP
HAMILTON 31811
COLLINS,JAMES E. 45 ACT FP
129 E. SECOND STREET, MANCHESTER 31816
HAAK,EDWARD DECKER 45 ACT PM
1030 E. SAMFORD AVENUE, AUBURN, ALA 36830

HIGGINS,ALEXIS C. 45 ACT PM
1224 OLD MILL RD., AUBURN,ALA. 36830
JACKSON,HENRY C. 45 ACT FP
MANCHESTER 31816
RAPER,HAL STUART 45 R
THE FOUNDATION, WARM SPRINGS 31830
REITH,PAUL L. 45 ACT OR
P.O. BOX 421, WARM SPRINGS 31830
RICE,JOSEPH F. 45 ACT I
WARM SPRINGS HOSPITAL, WARM SPRINGS 31830
ROBINSON,J.L. 45 ACT
P.O. BOX 481, CARROLLTON 30117
SMITH,JAMES W. 45 ACT FP
MANCHESTER 31816
WHITWORTH,JACK W. 45 ACT FP
1901 N. 2ND CT., LANETT, ALA. 36863

46—MITCHELL

ARWOOD,WILLIAM C.,JR. 46 ACT
PELHAM 31779
GUNTER,OLIVER L. 46 ACT FP
34 PERRY ST., CAMILLA 31730
MCNEILL,A. A.,JR. 46 ACT
CAMILLA 31730

47—MUSCOGEE
(Chattahoochee, Muscogee)

AGUIRRE, DENNIS M. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
ALVAREZ,ANGEL C. 47 ACT PD
7121 LULLWATER RD., COLUMBUS 31904
AMOS,WILLIAM L,JR 47 ACT OBG
P.O. BO 157, COLUMBUS 31902
ANDERSON,PAUL D. 47 DE4 I
MARTIN ARMY HOSP., FT. BENNING 31905
ANDREWS,JAMES R. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901
ARMSTRONG,GEORGE F.,JR. 47 ACT PD
THE MEDICAL CENTER, COLUMBUS 31902
BALDWIN,B. CARTER 47 ACT D
1217 PEACOCK AVE., COLUMBUS 31901
BARTLETT, GLENN H. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
BEACH,BESSIE MAE 47 S PD
17 BALENTINE DR., GREENVILLE, S. C. 29605
BERENSON,MORTON P. 47 ACT I
2748 SUE MACK DR., COLUMBUS 31906
BERMAN,DAVE 47 ACT D
1315 4TH AVE., COLUMBUS 31901
BERRY,ARTHUR N. 47 R OBG
1730 SANDY CIRCLE,112, CAPE CORAL,FLA 33904
BICKERSTAFF,HUGH J. 47 DE5 OBG
MEDICAL ARTS BLDG., COLUMBUS 31901
BILLINGS,CHARLES R. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
BLALOCK,JACK H.,JR. 47 ACT I
MEDICAL ARTS BLDG., COLUMBUS 31901
BLANCHARD,MERCER 47 DE5 PD
940 BLANFORD AVE., COLUMBUS 31906
BLANCHARD,MERCER C. 47 ACT PD
713 20TH ST., COLUMBUS 31904
BOLEN, RICHARD A. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
BOYTER,HENRY H. 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901
BREWER,PHILIP L. 47 ACT TS
MEDICAL ARTS BLDG., COLUMBUS 31901
BRIGHTWELL,LARRY E. 47 ACT SU
105 DOCTORS BLDG., COLUMBUS 31901
BRILL,HARRY H.,JR. 47 ACT I
1905 SEVENTH AVE., COLUMBUS 31901
BROCATO,SIMONE 47 ACT C
PHYSICIANS BLDG., COLUMBUS 31901
BURGER,CHARLES W. 47 I&R
MEDICAL CENTER, COLUMBUS 31901
BURK,BILLY D. 47 A OBG

BURR,MAX E. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31902
BUSH,JOHN 47 DE5 FP
P. O. BOX 141, COLUMBUS 31902
BUTLER,CLARENCE 47 ACT I
P. O. BOX 4199, COLUMBUS 31904
CABANISS,C. DANIEL 47 ACT I
P.O. BOX 951, COLUMBUS 31902
CARDEN,BRADLEY L. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
CARGILE,KENNETH R. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CARPENTER,ROBERT H. 47 ACT OBG
2404 13TH ST., COLUMBUS 31906
CARR,J. BRUCE 47 ACT NE
DOCTORS BUILDING, COLUMBUS 31901
CASTLEBERRY, ROBERT P. 47 S PD
4312 OLD MACON RD.,A-32, COLUMBUS 31907
CAULTON, CHARLES I. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CHASE,JERRY S. 47 I&R FP

CHASTAIN,J. B. 47 ACT PD
1710 HILTON AVE., COLUMBUS 31906
CHIPMAN,R. A. 47 ACT SU
PHYSICIANS BLDG., COLUMBUS 31901
COHEN,MARVYN D. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
COLLINS,FRANK B. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
CONGER,A. B. 47 ACT SU
206 DOCTORS BLDG., COLUMBUS 31901
CONN,LEE R. M. 47 ACT SU
1914 8TH AVE., COLUMBUS 31901
CONNER,GEORGE R. 47 ACT SU
1914 8TH AVE., COLUMBUS 31901
CORRY,ROBERT D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
CROSSE,JAMES E.W. 47 S U
MARTIN ARMY HOSPITAL, FT. BENNING 31905
CROWDER,JACKSON G. 47 ACT I
PHYSICIAN'S BLDG., COLUMBUS 31901
DASHIELL,WAVERLY B. 47 ACT OBG
P. O. BOX 157, COLUMBUS 31902
DAVIS,REX 47 S FP
MARTIN ARMY HOSP., FT. BENNING 31905
DEAN,ROBERT D. 47 ACT OBG
110 DOCTORS BLDG., COLUMBUS 31901
DEATON,J. H. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
DILLARD,GARY A. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
DODELIN,R. A. 47 ACT
2300 MANCHESTER RD #E1, COLUMBUS 31904
DODGEN,CHARLES W. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
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DUPONT,LOUIS 47 ACT SU
P. O. BOX 4199, COLUMBUS 31904
DURDEN,JOHN G.,JR. 47 ACT SU
1915 SEVENTH AVE., COLUMBUS 31901
EATON,JAMES M.,JR. 47 ACT U
717 20TH ST., COLUMBUS 31904
EDWARDS,FRANKLIN D. 47 ACT U
1430 3RD AVE., COLUMBUS 31901
EDWARDS,M. DELMAR 47 ACT SU
804 4TH AVE., COLUMBUS 31901
ELKINS,JAMES A. 47 DE1 OR
P.O. BOX 5364, COLUMBUS 31906
EPPS,GEORGE L. 47 R R
THE MEDICAL CENTER, COLUMBUS 31902
EVANS,JAMES A. 47 ACT ANES
P.O. BOX 2748, COLUMBUS 31902
FERRELL,M. LYNN 47 ACT FP
325 E. BROAD ST., SPARTA 31087

FIESELER, DAVID P. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
FLANAGAN,WM. C.,JR. 47 ACT OBG
P.O. BOX 157, COLUMBUS 31902
FLOWERS,ROBERT M. 47 ACT PD
2039 WARM SPRINGS RD., COLUMBUS 31904
FOSTER,THOMAS V. 47 ACT P
1953 SEVENTH AVE., COLUMBUS 31904
FOX,BRENT 47 ACT OALR
MEDICAL ARTS BLDG., COLUMBUS 31901
GALEN,NORMAN R. 47 DE4 U
MARTIN ARMY HOSP., FT BENNING 31905
GALEN,WESLEY K. 47 ACT D

GARNETT,ROBERT L. 47 ACT R

GILLIAM,O. D. 47 DE5 SU
P. O. BOX 2016, COLUMBUS 31902
GOLDMAN,KENNETH L. 47 ACT SU
905 CENTER ST., COLUMBUS 31901
GOLDMAN,NORMAN I. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
GOLDSMITH,HOWARD G. 47 ACT OR
2009 WARM SPRINGS RD., COLUMBUS 31901
GRAFFAGNINO,P. C. 47 ACT OBG
MEDICAL ARTS BLDG., COLUMBUS 31901
GRAHAM,WILLIAM L. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31901
GRIFFIN,JACK T. 47 ACT NS
2009 WARM SPRINGS RD., COLUMBUS 31904
GRINER,WALLACE 47 ACT
5740 WILTSHIRE DR., COLUMBUS 31907
HARRIS,J. HENRY WALKER 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
HAYES,WILLIAM H. 47 ACT PATH
1905 7TH AVE., COLUMBUS 31901
HAZOURI,LOUIS A. 47 ACT NS
P. O. BOX 5306, COLUMBUS 31906
HIRSCH,JACK 47 ACT I
909 CENTER ST., COLUMBUS 31901
HORN,EDGAR B. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901
HOUSE, ROBERT O. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
HOWARD,EDWARD K. 47 ACT SU
MEDICAL CENTER, COLUMBUS 31902
HUBBARD,GEORGE B.,JR. 47 ACT OPH
2019 7TH AVENUE, COLUMBUS 31904
HUDSON,RONALD M. 47 ACT
MEDICAL CENTER, COLUMBUS 31902
HUDSON,W. LLOYD 47 ACT PD
PHYSICIANS BLDG., COLUMBUS 31901
HUGHSTON,JACK C. 47 ACT OR
PHYSICIANS BLDG., COLUMBUS 31901
INGRAM, CHESTER W. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
JANECZKO, GREGORY F. 47 S ANES
MARTIN ARMY HOSPITAL, FT. BENNING 31905
JARRELL,FLOYD C.,JR. 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901
JARRELL,HAROLD G. 47 ACT OBG
629 20TH STREET, COLUMBUS 31904
JENKINS,CHESTER W. 47 S P
1930 PEPPERELL PKWY., OPELIKA,ALA. 36801
JENKINS,W. F. 47 DE5 R
1636 DIXON DR., COLUMBUS 31906
JERNIGAN,WM. C. T. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
JOHNSON,C. D. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
JONES,W. R. 47 DE5 PD
3055 SAGE RD., HOUSTON, TEXAS 77000
JORDAN,W. P. 47 DE5 U
2875 EDGEWOOD DRIVE, COLUMBUS 31906
KELLY,OLIVER 47 ACT ANES
404 DOCTORS BLDG., COLUMBUS 31901
KNELLER,SHELDON 47 S SU
MARTIN ARMY HOSP., FT. BENNING 31906
KRAATZ,ROBERT 47 ACT PATH
1800 LAKEWOOD DR., PHENIX CITY, ALA 36867
KRAVTIN,A. J. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
KURTZ,DONALD M. 47 ACT PATH
P.O. BOX 4176, COLUMBUS 31904
LAPIDES,LEON 47 ACT ALR
309 DOCTORS BLDG., COLUMBUS 31901
LAWLER,JACK 47 ACT OBG
629 20TH ST., COLUMBUS 31904
LEVY,LOUIS I. 47 ACT PD
1968 NORTH AVE., COLUMBUS 31901
LEWIS,JAMES W. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
LIGHTNER,JOEL E. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31902
LIPSCOMB,GEORGE E. 47 ACT R
P. O. BOX 2787, COLUMBUS 31902
LOVE,WILLIAM G.,JR. 47 ACT SU
P. O. BOX 6547, COLUMBUS 31907
LYLE, JAMES E. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
MARCUS,ROBERT D. 47 ACT OTO
1962 NORTH AVE., COLUMBUS 31901
MATHIAS, PHIL A. 47 S OBG
MARTIN ARMY HOSP., FT BENNING 31905
MAUGHON,BOB R. 47 ACT PN
1953 SEVENTH AVE., COLUMBUS 31904
MAZUR,W. P. 47 ACT P
P. O. BOX 6563, COLUMBUS 31907
MCALLISTER,KATHRYN 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902
MCCLINTON, JOE D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
MCGEE,THEODORE J. 47 ACT SU
ST. FRANCIS MED. PK., COLUMBUS 31904
MCNATT,EUGENE N. 47 S PATH
MARTIN ARMY HOSPITAL, FT. BENNING 31905
MCWHIRTER,WILLIAM P. 47 ACT

MEINE,FREDERICK J. 47 ACT R
1515 DARTMOUTH RD., COLUMBUS 31902
MILLER,GORDON C. 47 ACT I
2300 MANCHESTER X-WAY, COLUMBUS 31904
MOLNAR,EDMUND M. 47 ACT SU
101 DOCTORS BLDG., COLUMBUS 31901
MUNN,E. K. 47 DE5 OBG
2919 HAMILTON RD., COLUMBUS 31904
MURDOCK,ROBERT N. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
NELKEN,VIOLA D. 47 ACT ANES
DOCTORS BUILDING, COLUMBUS 31901
NEWBERRY,DAN C. 47 ACT ANES
DOCTORS BLDG., COLUMBUS 31901
NEWMAN,DONALD D. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
NEWSOM,BRUCE C. 47 ACT SU
633 19TH ST., COLUMBUS 31901
NEWTON,JOHN S. 47 ACT OPH
317 DOCTORS BLDG., COLUMBUS 30902
ODOM,HART S. 47 ACT
P.O. BOX 2299, COLUMBUS 31902
PATTERSON,MCLEOD 47 ACT FP
1612 ELMWOOD DR., COLUMBUS 31906
PATTON, ROBERT M. 47 ACT C
2300 MANCHESTER XWAY, COLUMBUS 31904
PEIKEN,ALAN S. 47 ACT I
102 DOCTORS BLDG., COLUMBUS 31901
PEIRCE,KENNETH E. 47 ACT AL
MEDICAL ARTS BLDG., COLUMBUS 31901
PETERS,HANS J. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31904
PIKE,BENJAMIN F. 47 ACT I
COLUMBUS MEDICAL CENTER, COLUMBUS 31902
PURKS,W. WARREN,JR. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
RAINES,JACK A. 47 ACT P
2601 CROSS COUNTRY DR,47, COLUMBUS 31906
RHEA,JAMES W. 47 A PD
ARAMCO BOX 2438, DHAHRAN SAUDI ARABIA
RICE,SAMUEL T. 47 ACT U
1430 THIRD AVE., COLUMBUS 31901

RICHTER,WILLIAM H. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
RIVERS,W. P.,JR. 47 ACT PD
2520 WYNNTON RD., COLUMBUS 31906
ROBERTS,DAVID B. 47 ACT OBG
2400 13TH ST., COLUMBUS 31906
ROBERTS,LUTHER J. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
RODDENBERY,S. A. 47 ACT SU
213 DOCTORS BLDG., COLUMBUS 31901
ROOF,JACK B.,JR. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
SCHILLER,HERBERT M. 47 ACT PATH
ST. FRANCIS HOSP., COLUMBUS 31901
SCHLEY,FRANCIS B.,JR. 47 ACT PD
303 11TH STREET, COLUMBUS 31901
SCHLEY,PHILIP T. 47 ACT U
717-20TH ST., COLUMBUS 31404
SCHNICK,JOHN C. 47 ACT FP
MEDICAL CENTER HOSP., COLUMBUS 31902
SCHUESSLER,GEORGE 47 ACT FP
302 DOCTORS BLDG., COLUMBUS 31901
SENEVIRATNE,D. G. 47 ACT EM
710 CENTER ST., COLUMBUS 31902
SERRATO,J. C.,JR. 47 ACT OR
DOCTORS BUILDING, COLUMBUS 31901
SHELTON,THOMAS G. 47 ACT I
1952 NORTH AVE., COLUMBUS 31901
SIGMAN,HOLLIS D. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
SIMPSON,MARSHALL A. 47 ACT P
BRADLEY CTR., COLUMBUS 31901
SIMPSON,WALTER W. 47 ACT EM
MEDICAL CENTER, COLUMBUS 31901
SIMS,WILLIAM G. 47 ACT PL
SUITE 212, DOCTORS BLDG, COLUMBUS 31901
SIZEMORE,JULIAN J.,JR. 47 ACT PD
808 21ST ST., COLUMBUS 31904
SKIPWORTH,GEORGE B. 47 ACT D

SMITH,GEORGE BERTLING 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901
SMITH,HILTON E. 47 ACT FP
CROSS COUNTRY PL. OFC.PK., COLUMBUS 31907
SMITH,LUTHER J.,II 47 ACT P
1953-7TH AVE., COLUMBUS 31901
SOUMA,MICKI C. 47 ACT OBG
P.O. BOX 951, COLUMBUS 31902
STAHLKUPPE,ROBERT F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
STAMEY,CHARLES C. 47 ACT OBG
629 20TH ST., COLUMBUS 31906
STAPLETON,JOHN L. 47 DE5 U
307 11TH ST., COLUMBUS 31901
STAR,FRANKLIN J. 47 ACT SU
905 CENTER ST., COLUMBUS 31901
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406 DOCTORS BLDG., COLUMBUS 31901
STEINHAUER,JAMES J. 47 ACT ANES
406 DOCTORS BLDG., COLUMBUS 31901
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2807 NORRIS RD., COLUMBUS 31907
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406 DOCTORS BLDG., COLUMBUS 31901
SULLIVAN,JAMES H. 47 ACT U
1430 3RD. AVE., COLUMBUS 31901
TALLEY,ROBERT E. 47 ACT SU
DOCTORS BLDG., COLUMBUS 31901
TAYLOR,WILLIAM M. 47 ACT R
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TERRELL,JOE F. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
THEUS,THOMAS L. 47 ACT I
PHYSICIANS BLDG., COLUMBUS 31901
THRASH,CALVIN L.,JR. 47 ACT I
2039 WARM SPRINGS RD., COLUMBUS 31901
TODD,JOHN M. 47 ACT FP
2121 WARM SPRINGS RD., COLUMBUS 31904
TURNER,H. H. 47 ACT I
DOCTORS BLDG., COLUMBUS 31901
TYRONE,NELSON O.,JR. 47 ACT U
717-20TH ST., COLUMBUS 31904
VAN DUYN,JOHN 47 DE5 PL
DOCTORS BLDG., COLUMBUS 31901
VARNER,W. D. 47 ACT OBG
2300 MANCHESTER RD., COLUMBUS 31904
VAUGHAN,R. H. 47 ACT SU
711 CENTER, COLUMBUS 31901
VENABLE,JAMES HEISKELL 47 ACT OBG
2300 MANCHESTER RD., COLUMBUS 31904
VIGRASS,HOWARD G. 47 ACT FP
MEDICAL CENTER, COLUMBUS 31902
WALLACE,ROBERT G. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
WALLER,ROY M.,JR. 47 ACT FP
203 PHYSICIANS BLDG., COLUMBUS 31901
WALSH,W. MICHAEL 47 I&R
105 DOCTORS BUILDING, COLUMBUS 31901
WARD,JAMES 47 ACT OBG
DOCTORS BLDG., COLUMBUS 31901
WARNOCK,RALPH P. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
WASDEN,HOWELL A. 47 I&R FP
MEDICAL CENTER, COLUMBUS 31902
WATRAS,CHARLES S. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
WATSON,DAVIS RONALD 47 ACT OALR
317 DOCTORS BLDG., COLUMBUS 31901
WATSON,JOHN D.,JR. 47 ACT R
P.O. DRAWER 2787, COLUMBUS 31902
WEBBER,JOSEPH M. 47 ACT PATH
633-19TH ST., COLUMBUS 31901
WELLS,T. W.,JR. 47 DE4 OPH
MARTIN ARMY HOSP., FT. BENNING 31905
WHATLEY,GEORGE S. 47 ACT OR
2009 WARM SPRINGS RD., COLUMBUS 31904
WHATLEY,WILLIAM B. 47 I&R
MEDICAL CENTER, COLUMBUS 31902
WHITAKER,CECIL F. 47 ACT OBG
629 20TH ST., COLUMBUS 31902
WOLFF,LUTHER H. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
WOLFF,WM. A. 47 ACT SU
MEDICAL ARTS BLDG., COLUMBUS 31901
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1909 IRIS DRIVE, COLUMBUS 31906
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1310 13TH AVE., COLUMBUS 31901
YOE,LIONEL MEREDITH 47 ACT OPH
DOCTORS BLDG., COLUMBUS 31901
ZUBOWICZ,GEORGE 47 ACT P
2000 16TH AVE., COLUMBUS 31901

48—NEWTON-ROCKDALE

ABBOTT,EMILE G. 48 ACT I
2121 FLAT SHOALS RD., CONYERS 30207
BONAU,ROGELIO 48 ACT SU
5303 ADAMS ST., COVINGTON 30209
BROWN,JOSEPH CHRISTOPHER 48 ACT FP
CONYERS 30207
CEBULA,JEROME M. 48 ACT PATH
2537 HIGHLAND DR., CONYERS 30207
FAULKNER,ROBERT L. 48 ACT FP
1022 TATE ST., COVINGTON 30209
FREYRE,ROBERT C. 48 ACT FP
943 COURT ST., CONYERS 30207
FUTCH,WILLIAM A. 48 ACT FP
CONYERS 30207
PATY,ROBERT M.,JR. 48 DE5 SU
P. O. BOX 527, OXFORD 30267
PULLIAM,MORRIS M. 48 DE2 FP
RT. 4, ELIZABETH ST., COVINGTON 30209
PURCELL,J. W.,JR. 48 ACT FP
5278 ADAMS ST., COVINGTON 30209
TANNER,TERRELL B. 48 ACT FP
110 CLARKE STREET, OXFORD 30267

TUCK,G. G. 48 ACT FP
P.O. BOX 1058, COVINGTON 30209

49—OCONEE VALLEY
(Greene, Hancock, Morgan)

DICKENS,C. H. 49 DE5 PD
903 DIXIE AVE., MADISON 30650
GIBSON,WALLACE M. 49 ACT
106 N. JEFFERSON ST., EATONTON 31024
GREEN,GEORGE F. 49 ACT FP
325 E. BROAD ST., SPARTA 31087
LEWIS,L. K. 49 ACT
BOX 552, MADISON 30650
MCGEARY,W. C.,JR. 49 ACT FP
167 W. JEFFERSON ST., MADISON 30650
PAGSISIHAN,FRANCISCO H. 49 S SU
P.O. BOX 10, MADISON 30650
PARKER,J. LEE 49 ACT FP
GREENSBORO 30642
RHODES,WM. H.,JR. 49 ACT FP
100 SCOTT ST., UNION POINT 30669
THORNTON,H. A. 49 ACT FP
P. O. BOX 326, GREENSBORO 30642
WADE,LEO J. 49 ACT FP
208 VEASEY ST., UNION POINT 30669

50—OCMULGEE
(Bleckley, Dodge, Pulaski, Wilcox)

ARNOLD,M. F. 50 ACT FP
TAYLOR MEMORIAL HOSP., HAWKINSVILLE 31036
BAKER,W. R. 50 ACT SU
HAWKINSVILLE 31036
BATTS,A. S. 50 ACT
HAWKINSVILLE 31036
BIVINS,BLAKE S. 50 ACT FP
BEECH ST., COCHRAN 31014
BRIGGS,WILLIAM J,III 50 ACT FP
MILAN 31060
BROOKS,CHARLES P. 50 ACT FP
P.O. BOX 35, COCHRAN 31014
COLEMAN,W. E. 50 ACT FP
HAWKINSVILLE 31036
CONNER,D. H. 50 ACT
P. O. BOX 629, EASTMAN 31023
DURHAM,W. P. 50 DE5 OALR
1410 HUMMINGBIRD DR., HILLSBORO,TEXAS 76645
HOLDER,F. P.,JR. 50 ACT SU
P. O. BOX 569, EASTMAN 31023
JUN,CHANNING S. 50 ACT SU
702 SECOND AVE. W., EASTMAN 31023
KIM,SUNG H. 50 ACT PATH
GRIFFIN ST., EASTMAN 31023
LONG,HAROLD W. 50 ACT FP
P. O. BOX 400, EASTMAN 31023
PATTERSON,GEORGE W. 50 ACT FP
DODGE CT. HOSP., EASTMAN 31023
SMITH,R. L. 50 ACT FP
COCHRAN 31014
TSENG,GEORGE Y. 50 ACT PD
1009 N. MONROE ST., ALBANY 31701
WALKER,GEORGE S.,III 50 ACT I
GRIFFIN ST.,PROF.CNTR., EASTMAN 31023
WEIGLE,KEITH E. 50 ACT R
DODGE COUNTY HOSPITAL, EASTMAN 31023

53—RANDOLPH-STEWART-TERRELL

ALLEN,THOMAS M. 53 ACT FP
JOHNSON ST., DAWSON 31742
BATES,JOHN G. 53 ACT FP
201 RANDOLPH ST., CUTHBERT 31740
MARTIN,ROBERT B.,III 53 ACT SU
201 RANDOLPH ST., CUTHBERT 31740
MARTIN,WALTER D. 53 ACT FP
DAWSON 31742
MAYO,EARL A.,JR 53 ACT
RICHLAND 31825
SHEFFIELD,CHARLES RAY 53 ACT FP
JOHNSON STREET, DAWSON 31742
SIMS,A. R. 53 ACT
RICHLAND 31825
WARD,CHARLES M. 53 ACT FP
107 1/2 LEE STREET, DAWSON 31742

54—RICHMOND
(Glascock, Richmond)

ABELE,DONALD C. 54 ACT D
MED. COLLEGE OF GA., AUGUSTA 30902
ABOUL-KHAIR,SIDKY 54 ACT I
304 JONES AVE., WAYNESBORO 30830
ADAMS,HANS W. 54 ACT I
380 HOSPITAL DR #460, MACON 31201
AGOSTAS,W. N. 54 ACT I
1021 15TH STREET, AUGUSTA 30901
AKAMATSU,YASUYUKI 54 ACT PATH
MED. COLLEGE OF GA., AUGUSTA 30902
ALLEN,LANE H. 54 ACT
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
ALLEN,MARSHALL B.,JR. 54 ACT N
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
ALTHISAR,H. M. 54 ACT FP
VA HOSP., AUGUSTA 30904
ARRINGTON,JOHN H.,III 54 ACT PATH
PATHOLOGY DEPT, MCG, AUGUSTA 30902
ASOKAN,SANKARAN K. 54 ACT I
MED COLLEGE OF GA, AUGUSTA 30902
AZIZ,EZZAT M. 54 ACT PD
MEDICAL COLLEGE OF GA., AUGUSTA 30902
BAILEY,HENRY WRIGHT 54 ACT
1500 JOHNS RD., AUGUSTA 30904
BAILEY,JOSEPH P. 54 ACT I
TALMADGE HOSP., AUGUSTA 30902
BAILEY,T. E. 54 ACT PD
1111 DRUID PARK AVE., AUGUSTA 30904
BARFIELD,WILLIAM E. 54 ACT OBG
1445 HARPER ST., AUGUSTA 30902
BARFIELD,WILLIAM E.,JR. 54 A OBG
MED. COLLEGE OF GA., AUGUSTA 30902
BATTEY,L. L. 54 ACT I
1021 15TH STREET, AUGUSTA 30901
BAZEMORE,J. MALCOLM 54 ACT D
1467 HARPER ST., AUGUSTA 30902
BECTON,JAMES L. 54 ACT OR
1521 ANTHONY RD., AUGUSTA 30904
BEDINGFIELD,W. R.,JR. 54 ACT I
503 GEORGIA AVENUE, N.AUGUSTA,SC 29841
BELK,BEVERLY 54 ACT PD
P.O. BOX 28, AUGUSTA 30903
BELL,J. E. 54 ACT PD
1411 GWINNETT ST., AUGUSTA 30902
BENNETT,J. W. 54 ACT PD
1467 HARPER ST., AUGUSTA 30902
BERG,EDWARD W. 54 ACT OR
MEDICAL COLLEGE OF GA., AUGUSTA 30902
BIGGER,JOHN F.,JR. 54 ACT OPH
905-15TH ST.,STE E, AUGUSTA 30901
BILLINGHURST,GEORGE A. 54 DE1 FP
P.O. BOX 2354, STUART, FLA. 33494
BITTLE,CHARLES R. 54 ACT ANES
812 13TH ST., AUGUSTA 30901
BLALOCK,H. SHERMAN 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
BLANCHARD,THOMAS W. 54 ACT U
1502 ANTHONY RD., AUGUSTA 30904
BLITCH,PIERCE G.,JR. 54 ACT I
1505 WINTER ST., AUGUSTA 30904
BLIVEN,FLOYD E.,JR. 54 ACT OR
TALMADGE MEMORIAL HOSPITAL, AUGUSTA 30902

BOHLER,CLORINDA S. 54 ACT EM
2279 WRIGHTSBORO RD., AUGUSTA 30904
BOTNICK,ROBERT S. 54 ACT I
1003 CHAFEE AVE., AUGUSTA 30904
BOWDEN,TALMADGE A.,JR. 54 ACT SU
MED. COLLEGE OF GA., AUGUSTA 30902
BOWEN,J. B. 54 ACT SU
842 GREENE ST., AUGUSTA 30902
BOWEN,JOHN L. 54 DE2 PD
P. O. BOX 1637, ORANGEBURG, S. C. 29115
BOWLES,LESTER L. 54 ACT P
P. O. BOX 4687, MARTINEZ 30907
BOYD,CLAUD A.,JR. 54 ACT D
1509 ANTHONY RD., AUGUSTA 30904
BOYD,WM. S. 54 ACT OBG
1503 WINTER ST., AUGUSTA 30904
BRACKNEY,EDWIN L. 54 ACT SU
BOX 521 V.A. HOSPITAL, TUSKEGEE, ALA 36083
BRAND,ROBERT L. 54 ACT OR
1132 DRUID PARK AVE., AUGUSTA 30904
BRANSOME,EDWIN D.,JR. 54 ACT I
MED. COLLEGE OF GA., AUGUSTA 30902
BRIDGES,H. BENTON 54 ACT OR
1413 GWINNETT ST., AUGUSTA 30902
BRIDGES,MERCER T. 54 ACT OR
1515 POPE AVE., AUGUSTA 30904
BRONSTEIN,EDWIN S. 54 ACT OBG
MED. COLLEGE OF GA., AUGUSTA 30902
BROWN,ALLEN N. 54 ACT FP
1439 DRUID PK. AVE, #F, AUGUSTA 30904
BROWN,JAMES A. 54 ACT OPH
3651 WHEELER RD, SUITE 100, AUGUSTA 30904
BROWN,MARK 54 ACT R
TALMADGE MEMORIAL HOSP., AUGUSTA 30902
BROWN,SOLOMON K. 54 ACT R
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STOCKS,S. ALLAN 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904
STODDARD,LELAND D. 54 ACT PATH
MEDICAL COLLEGE OF GA., AUGUSTA 30902
STRETCHER,GEORGE S. 54 ACT D
MCG, AUGUSTA 30902
STRONG,JAMES S. 54 ACT R
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STRONG,WILLIAM B. 54 ACT PDC
MED. COLLEGE OF GA., AUGUSTA 30902
SULLIVAN,DANIEL B. 54 ACT SU
1430 HARPER ST., AUGUSTA 30902
SUSSMAN,HY C. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
SWIFT,THOMAS R. 54 ACT N
MCG, DEPT. NEU, AUGUSTA 30902
TALLEDO,O. EDUARDO 54 ACT OBG
MED COLLEGE OF GA., AUGUSTA 30904
TANENBAUM,JULIAN B. 54 ACT PD
2315 CENTRAL AVE., AUGUSTA 30904
TANNER,ROBERT E. 54 ACT
1467 HARPER ST., AUGUSTA 30902
TEESLINK, C. REX 54 ACT R
1467 HARPER ST., AUGUSTA 30902
THIGPEN,CORBETT H. 54 ACT P
1423 HARPER ST., AUGUSTA 30902
THOMAS,DAVID R.,III 54 ACT PUL
1467 HARPER ST #208, AUGUSTA 30902
THOMAS,DAVID R.,JR. 54 ACT I
1467 HARPER ST., AUGUSTA 30902
THOMAS,LUTHER M.,JR. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904
THOMAS,R. P. 54 ACT OPH
3651 WHEELER RD.,STE.100, AUGUSTA 30904
THORNTON,NANCY 54 ACT PD
VA HOSP., AUGUSTA 30904
THREEFOOT,SAM A. 54 ACT I
DEPT MED TULANE UNIV, NEW ORLEANS, LA 70112
THURMOND,A. G. 54 ACT OBG
524 GEORGIA AVE., N. AUGUSTA, S. C. 29841
THURMOND,GEORGE W. 54 ACT OTO
2283 WRIGHTSBORO RD., AUGUSTA 30904
THURMOND,J. W. 54 DE5 OBG
1167 UNIVERSITY PL., AUGUSTA 30902
TILLERY,WM. V.,III 54 ACT OPH
1514 ANTHONY RD., AUGUSTA 30904
TREST,FRED A. 54 ACT P
MEDICAL COLLEGE OF GA, AUGUSTA 30902
VAN GIESEN,GEO. E.,JR. 54 ACT I
3623 DEWEY GRAY CIR., AUGUSTA 30904
VANDERZALM,THEODORA 54 ACT R
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
VOLPITTO,P. P. 54 ACT ANES
TALMADGE MEM. HOSP., AUGUSTA 30902
WALKER,JOHN H. 54 ACT PATH
VA HOSPITAL, AUGUSTA 30904
WALTERS,GORDON E. 54 ACT I
1500 JOHNS RD., AUGUSTA 30904
WARD,DANIEL F. 54 ACT P
3651 WHELER RD., AUGUSTA 30904
WATERS,A. J. 54 ACT ANES
3405 SASANQUA DR., AUGUSTA 30904

WATSON,W. G. 54 ACT OBG
1167 UNIVERSITY PL., AUGUSTA 30902
WEBSTER,PAUL D.,III 54 ACT GE
MED. COLLEGE OF GEORGIA, AUGUSTA 30902
WEEKS,RICHARD B. 54 DE1 SU
4230 13TH ST, ST SIMONS ISLAND 31522
WEIHE,JAMES H. 54 I&R
MEDICAL COLLEGE OF GA., AUGUSTA 30902
WELTER,DONALD J. 54 ACT FP

WHELCHEL,MERRITT C. 54 ACT OPH
905 15TH ST, #E, AUGUSTA 30902
WILDS,P. L. 54 ACT OBG
MEDICAL COLLEGE OF GA., AUGUSTA 30902
WILKES,W. A. 54 ACT PD
1203 HIGHLAND AVE., AUGUSTA 30904
WILLIAMS,DAVID C.,JR. 54 ACT U
1142 DRUID PARK, AUGUSTA 30904
WILLIAMS,GEORGE P. 54 ACT OBG
1505 WINTER ST., AUGUSTA 30904
WILLIAMS,JACK B. 54 ACT ANES
812 13TH ST., AUGUSTA 30901
WILLIAMS,JOHN L. 54 ACT NS
1521 POPE AVE., AUGUSTA 30904
WIRSING,CHARLES J.,JR 54 ACT P
216 SIMMONS PL., AUGUSTA 30907
WITHAM,A. CALHOUN 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WITHERINGTON,ROY 54 ACT U
MED COLLEGE OF GA., AUGUSTA 30902
WOMBLE,J. G. 54 ACT SU
1256 MERRY ST., AUGUSTA 30904
WRAY,BETTY B. 54 ACT PD
MED. COLLEGE OF GA., AUGUSTA 30902
WRAY,CHARLES H. 54 ACT SU
TALMADGE MEM. HOSP., AUGUSTA 30902
WRIGHT,CLAUDE STARR 54 ACT I
MEDICAL COLLEGE OF GEORGIA, AUGUSTA 30902
WRIGHT,GEO. W. 54 DE5 SU
2913 BRANSFORD RD., AUGUSTA 30904
WYLIE,M. H. 54 ACT SU
1403 GWINNETT ST., AUGUSTA 30902
YAGHMAI,FARIVAR 54 ACT PATH
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55—SCREVEN

FREEMAN,JAMES C. 55 ACT FP
106 E. TELEPHONE ST., SYLVANIA 30467
HAWKINS,KATRINE RAWLS 55 ACT FP
P. O. BOX 518, SYLVANIA 30467
HOGSETTE,GERALD B. 55 ACT SU
P.O. BOX 179, SYLVANIA 30467
KENT,WILLIAM R. 55 ACT FP
P. O. BOX 218, SYLVANIA 30467

56—SOUTH GEORGIA
(Berrien, Clinch, Cook, Echols, Lanier, Lowndes)

ACREE,RUSSELL A. 56 ACT FP
HAHIRA 31632
AGUERO,OSCAR E. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31601
ALFONSO,JOSE G. 56 ACT PD
310 JANET ST., VALDOSTA 31601
AUSTIN,G. J.,JR. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603
BARKER, CHARLES O. 56 ACT FP
P.O. BOX 2999, VALDOSTA 31601
BARTON,DEWEY L. 56 ACT R
DOCTORS BLDG., VALDOSTA 31603
BEALL,AVERY P. 56 ACT FP
P. O. BOX 129, ADEL 31620
BECHTEL,H. BERNARD 56 ACT D
2101 N. PATTERSON ST., VALDOSTA 31603
BENNETT,VAN B. 56 ACT I
RT. 1, BOX 2, VALDOSTA 31601
BRANCH,DAVID L.,JR. 56 ACT OR
DOCTORS BLDG., VALDOSTA 31603
BRANNEN,J. H. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31603
BROWNSBERGER,JOHN F. 56 DE5 SU
LAKELAND 31635
BURNS,D. L. 56 DE5 FP
BOX 3075 CASTLE PK STA, VALDOSTA 31601
CAMPA,JOSE C. 56 ACT OR
1807 JERRY JOHNS DR., VALDOSTA 31601
CHISHOLM,LEWIS F. 56 ACT FP
ROBBINS CLINIC, HOMERVILLE 31634
CLEMENTS,FRED N. 56 ACT FP
ADEL 31620
COLEMAN,FRANCIS,W. W. 56 ACT I
501 WOODROW WILSON DR., VALDOSTA 31601
CREECH,EARL L. 56 ACT OR
P. O. BOX 2261, VALDOSTA 31601
DAVIS,BYRON S. 56 ACT PATH
P.O. BOX 2658, VALDOSTA 31601
DENNARD, JAMES E. 56 ACT OALR
DOCTORS BLDG, STE. 108, VALDOSTA 31601
DICKSON,WILLIAM A. 56 ACT FP
408 E. STANFILL, HAHIRA 31632
DISMUKE,JAMES C. 56 ACT FP
P. O. BOX 409, ADEL 31620
DRURY,WILEY L. 56 ACT ANES
P.O. BOX 1727, VALDOSTA 31601
ELDRIDGE,F. G. 56 DE5 R
2307 RIVERHILL DR., VALDOSTA 31601
GEE,W. N.,JR. 56 ACT I
401 E. JANE ST., VALDOSTA 31601
GIDDENS,I. S. 56 ACT FP
LAKELAND 31635
GREER,MACK V. 56 ACT FP
P. O. BOX 146, HOMERVILLE 31634
GROW,WILLIAM R. 56 ACT I
311 WOODROW WILSON DR., VALDOSTA 31601
HINER,JERRY L. 56 ACT FP
BOX 898, BAKER,MONTANA 59313
HOBBY,CHARLES F. 56 ACT R
104 DOCTORS BLDG., VALDOSTA 31603
HODGES,CHAS. A.,JR. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31601
HOLT,EDWARD 56 ACT FP
807 N. PARRISH AVE., ADEL 31620
HOUSTON,JOSEPH S. 56 ACT P
100 S. EDGEWOOD DR, DOTHAN AL 36301
HOUSTON,JOSEPH S. 56 ACT P
305 EMORY ST., VALDOSTA 31603
JOHNSON,A. M. 56 ACT PD
DOCTORS BLDG., VALDOSTA 31603
LAWSON,QUENTIN T. 56 ACT U
401 WOODROW WILSON DR., VALDOSTA 31601
LITTLE,ALEX G.,JR. 56 R SU
RT. 1, BOX 4, VALDOSTA 31601
MANN,GUY W. 56 ACT FP
116 HOSPITALD DR., LAKELAND 31635
MARTINEZ,MARCIAL E. 56 ACT R
P. O. BOX 303, ADEL 31620
MATHIS,JAMES W. 56 ACT SU
209 PENDLETON DR., VALDOSTA 31601
MCBRIDE,MICHAEL T. 56 ACT OBG
P.O. BOX 2978, VALDOSTA 31601
MEADORS,JASON LAWRENCE 56 ACT R
P. O. BOX 2254, VALDOSTA 31601
MILLER,J. M. 56 ACT OBG
2307 N. PATTERSON ST., VALDOSTA 31603
MIXSON,E. HARRY 56 ACT
DOCTORS BLDG., VALDOSTA 31603
MIXSON,JOYCE F.,JR. 56 ACT OBG
105 DOCTORS BUILDING, VALDOSTA 31603
MOSELEY,THOMAS H. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603
MOYE,BEN H. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601
NATION,THOMAS C. 56 ACT PATH
P.O. BOX 2658, VALDOSTA 31601

NELSON,FRED L.,JR. 56 ACT R
P.O. BOX 308, NASHVILLE 31639
NELSON,JOHN W. 56 ACT PATH
P.O. BOX 1727, VALDOSTA 31601
NUTT,RICHARD L. 56 ACT ANES
P. O. BOX 1727, VALDOSTA 31603
OWENS,B. G. 56 DE5 SU
111 E. ALDEN AVE., VALDOSTA 31603
PARKHURST,ROBERT D. 56 ACT PD
107 WOODROW WILSON, VALDOSTA 31601
PARROTT,JESSE LYLE 56 ACT FP
HAHIRA 31632
PETERS,JAMES S. 56 ACT R
4513 CLUB CIR. NE, ATLANTA 30319
PURVIS,JERRY G. 56 ACT SU
106 W. NORTHSIDE DR, VALDOSTA 31601
QUATTLEBAUM,ROBERT B. 56 ACT R
SUITE 104,DRS. BLDG., VALDOSTA 31601
RETTERBUSH,W. C. 56 ACT SU
BOX 2313, VALDOSTA 31603
RODRIGUEZ,HUMBERTO 56 ACT SU
P. O. BOX 2274, VALDOSTA 31601
SAUNDERS,A. F. 56 DE5 OBG
P. O. BOX 2035, VALDOSTA 31603
SHERMAN,HENRY T. 56 R I
P.O. BOX 1409, VALDOSTA 31601
SMITH,FRANK Q. 56 ACT OBG
P. O. BOX 2748, VALDOSTA 31601
SMITH,FRED C. 56 ACT SU
DOCTORS BLDG., VALDOSTA 31603
SMITH,HENRY BRIGGS 56 ACT ALR
DOCTORS BLDG., VALDOSTA 31603
SMITH,T. H. 56 DE5 OALR
3024 N. PATTERSON ST., VALDOSTA 31601
SMITH,THOS. H.,JR. 56 ACT OPH
3024 N. PATTERSON ST., VALDOSTA 31601
STECKER,DONALD C. 56 ACT
LOUIS SMITH MEM. HOSP., LAKELAND 31635
STUBBS,JOE C. 56 ACT I
101 NORTHSIDE DR., VALDOSTA 31601
STUMP,ROBERT L.,JR. 56 ACT FP
1624 BOONE DR., VALDOSTA 31603
THOMPSON,E. F. 56 DE5 OALR
DOCTORS BUILDING, VALDOSTA 31603
THOMPSON,EMORY F. 56 ACT OALR
DOCTORS BUILDING, VALDOSTA 31603
THRELKELD,WILLIAM A. 56 ACT P
P. O. BOX 1727, VALDOSTA 31603
TOVAR-DE-HOYOS,MANUEL 56 ACT FP
2311 N. PATTERSON ST., VALDOSTA 31601
WINSTON,R. K. 56 ACT OPH
DOCTORS BLDG., VALDOSTA 31603
YEAGER,OTIS WAYNE 56 ACT PD
P. O. BOX 2127, VALDOSTA 31603
YOULES,OWEN K.,JR. 56 ACT OBG
DOCTORS BLDG., VALDOSTA 31603

57—SOUTHEAST GEORGIA
(Montgomery, Tattnall, Toombs, Treutlen, Wheeler)

BARFIELD,JAMES E. 57 ACT
300 ARLINGTON DR., VIDALIA 30474
BEDINGFIELD,W. H. 57 ACT FP
P. O. BOX 629, VIDALIA 30474
CONNER,H. I. 57 ACT SU
P. O. BOX 1107, VIDALIA 30474
DARBY,V. L. 57 DE5 SU
706 CHURCH ST., VIDALIA 30474
DEJARNETTE,ROBERT H.,JR 57 ACT SU
702 MEADOWS LANE, VIDALIA 30474
DRAKE,CHAS. H. 57 ACT FP
121 N. CASWELL, GLENNVILLE 30427
GORDON,JAMES H. 57 S PH
TOOMBS COUNTY HEALTH DEPT., LYONS 30436
JELKS,LOUIS R. 57 ACT SU
JELKS CLINIC, BOX 128, REIDSVILLE 30453
MCARTHUR,JOHN D. 57 ACT
LYONS 30436
MCNAIR,WILLIAM P. 57 ACT FP
SOPERTON 30457
MERRITT,GEORGE W. 57 ACT FP
300 ARLINGTON DR., VIDALIA 30474
YATES,A. J.,JR. 57 ACT FP
SOPERTON 30457

58—SOUTHWEST GEORGIA
(Calhoun, Clay, Early, Miller, Quitman)

CHEN,ER-WEI 58 ACT FP
172 PINE AVE.,SW, GRIFFIN 30223
CROWDIS,JAS. HUDSON,JR. 58 ACT
BLAKELY 31723
GILES,EUGENE H. 58 ACT FP
322 S. MAIN ST., BLAKELY 31723
JENNINGS,ROBERT E. 58 ACT
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
LASSITER,HOMER L. 58 ACT FP
ARLINGTON CITY HOSPITAL, ARLINGTON 31713
MERRITT,HINTON J. 58 ACT FP
COLQUITT 31737
MERRITT,JAMES W. 58 DE1 FP
COLQUITT 31737
MONTES,ISMAEL G. 58 ACT SU
1605 SHOTWELL ST., BAINBRIDGE 31717
RENTZ,TURNER W. 58 ACT FP
COLQUITT 31737
WETHERBY,DAVID 58 ACT
FT. GAINES 31751
WOOD,HOMER P. 58 ACT FP
CLAY COUNTY HOSPITAL, FORT GAINES 31751

59—SPALDING
(Butts, Henry, Lamar, Spalding)

ALONSO,JORGE P. 59 ACT ANES
604 S. 8TH ST., GRIFFIN 30223
AUSTIN,J. L. 59 ACT OALR
610 S. 8TH ST., GRIFFIN 30223
BLACK,GRADY E. 59 ACT PD
567 S. 9TH ST., GRIFFIN 30223
BLANCHARD,HUBERT H. 59 ACT P
720 HOLMES ST., BARNESVILLE 30204
BLISSIT,JOSEPH A. 59 ACT I
169 DECATUR ROAD, MCDONOUGH 30253
BRANDON,R. V. 59 DE1 FP
WESTBURY MED CARE HOME, JENKINSBURG 30234
BROWN,GEORGE W. 59 ACT R
686 S. 8TH STREET, GRIFFIN 30223
BUNYASARANAND,PRICHA 59 ACT D
610 S. 8TH ST., GRIFFIN 30223
CASWELL,ROBERT J.,II 59 ACT R
686 S. 8TH ST., GRIFFIN 30223
CLOUSE,JOHN E.,JR. 59 ACT FP
682 S. 8TH ST., GRIFFIN 30223
COOPER,FLOYD C.,III 59 ACT P
306 S. 8TH ST., GRIFFIN 30223
COPELAND,H. J. 59 DE1 SU
615 E. COLLEGE ST., GRIFFIN 30223
COX,JOEL E. 59 ACT OBG
503 SOUTH 8TH ST, GRIFFIN 30223
CRAWFORD,JOHN B. 59 ACT FP
BARNESVILLE 30204
DUKE,GRADY F. 59 ACT SU
436 S . HILL ST., GRIFFIN 30223
DUNAWAY,JAMES BOYD 59 ACT PD
712 S. 8TH STREET, GRIFFIN 30223
FLOYD,T. J.,JR. 59 ACT SU
506 S. 8TH ST., GRIFFIN 30223
FOSTER,GURDON R.,JR. 59 ACT FP
MCDONOUGH 30253
FOSTER,HENRY A. 59 ACT
319 S. 9TH ST., GRIFFIN 30223

GRAYSON,JOHN T. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
HAJOSY,RALPH W. 59 ACT OR
815 S. 8TH ST., GRIFFIN 30223
HALL,JESSE DENNY,JR. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
HENRY,GEORGE T. 59 ACT FP
BARNESVILLE 30204
HUNT,THOMAS JEFFERSON 59 ACT SU
610 S. 8TH ST., GRIFFIN 30223
JACKSON,J. H. 59 DE5 FP
10 MARKET ST., BARNESVILLE 30204
JONES,A. P. 59 ACT FP
BOX 757, GRIFFIN 30223
KELLEY,J. WELDON 59 ACT SU
602 S. 8TH ST., GRIFFIN 30223
KING,JOHN LAMAR 59 ACT U
8TH STREET, GRIFFIN 30223
KING,WM. R.,JR. 59 ACT SU
708 S. 8TH STREET, GRIFFIN 30223
KREPPS,ARTHUR C.,II 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223
LANDHAM,JACKSON W.,JR. 59 ACT I
743 S. 8TH ST., GRIFFIN 30223
LESCHER,CHARLES F. 59 S R
14627 S.W. 63RD CT., MIAMI, FLA. 33158
MACIAS,F. M. 59 ACT ANES
24 MAIN ST., HAMPTON 30228
MONTERO,ENRIQUE 59 ACT ANES
546 S. 8TH ST., GRIFFIN 30223
OSHLAG,ABRAHAM M. 59 ACT I
3175 HILL STREET, GRIFFIN 30223
REBUELTA,MANUEL A. 59 ACT FP
169 DECATUR ROAD, MCDONOUGH 30253
RELEFORD,CHARLES C. 59 ACT
218 W. BROAD ST., GRIFFIN 30223
REYNOLDS,KENNETH H. 59 ACT I
231 GRAEFE ST., GRIFFIN 30223
SKINNER,JAMES M. 59 ACT OBG
610 SOUTH EIGHTH STREET, GRIFFIN 30223
SMAHA,T. G. 59 ACT G
600 SOUTH 8TH STREET, GRIFFIN 30223
SMITH,WILLIAM V. 59 ACT OBG
503 S. 8TH ST., GRIFFIN 30223
STUCKEY,ANN D. 59 ACT PD
MEMORIAL DR., DALONEGA. 30533
STUCKEY,ANN D. 59 ACT PD

TAKLE,LEIV M. 59 ACT OPH
646 S. 8TH ST., GRIFFIN 30223
TATUM,L. L.,JR. 59 ACT U
653 S. 8TH ST., GRIFFIN 30223
TRAYLOR,S. B. 59 ACT FP
BARNESVILLE 30204
WALKER,GEO. L. 59 R
709 MAPLE DR., GRIFFIN 30223
WILLIAMS,VIRGIL B. 59 ACT SU
571 SOUTH 9TH STREET, GRIFFIN 30223
ZEVALLOS,CARLOS A. 59 ACT
SPALDING CTY HOSP., GRIFFIN 30223

60—STEPHENS-RABUN

CONOLEY,KENNETH 60 ACT PD
304 N. SAGE, TOCCOA 30577
COPELAN,ELTON L. 60 ACT OBG
TOCCOA CLINIC, TOCCOA 30577
DOSS,MELVIN C. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
FLYNN,THOMAS F. 60 DE4 SU
U. S. PHS. HOSP. 6500, NORFOLK, VA. 23508
FOWLER,JOHN E. 60 ACT FP
P. O. BOX 825, CLAYTON 30525
GILBERT,CLYDE D. 60 ACT OBG
800 E. DOYLE ST., TOCCOA 30577
GRAVES,EDWARD M. 60 ACT
MEDICAL ARTS BLDG., TOCCOA 30577
HAY,S. H. 60 ACT I
TOCCOA 30577
HELLENGA,IRVING D. 60 ACT FP
TOCCOA CLINIC, TOCCOA 30577
KING,GEORGE C. 60 ACT FP
BOX 1209, CLAYTON 30525
KNOWLTON,JAMES W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
LAMPROS,C. PETER 60 ACT R
800 DOYLE ST., TOCCOA 30577
LAWRENCE,JOHN C. 60 ACT PD
800 E. DOYLE ST., TOCCOA 30577
LEE,FRED M. 60 ACT U
800 E. DOYLE ST., TOCCOA 30577
MCNEELY,HENRY H. 60 ACT FP
TOCCOA 30577
PAULY,ROBERT P. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
PICKENS,JAMES C. 60 ACT OBG
800 E DOYLE ST., TOCCOA 30577
PITTARD,M. D. 60 ACT FP
TOCCOA 30577
SCHAEFER,W. B. 60 DE1 SU
19525 SW 248TH ST., HOMESTEAD,FLA. 33030
SETZER,EDWARD H. 60 ACT I
800 E. DOYLE ST., TOCCOA 30577
SINGER,ARTHUR G. 60 ACT R
TOCCOA 30577
SLATE,ROBERT W. 60 ACT SU
800 E. DOYLE ST., TOCCOA 30577
THOMPSON,ROBERT E. 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
TURNER,RICHARD J. 60 ACT
P.O. BOX 746, CLAYTON 30525
VEVERKA,FRANK 60 ACT FP
800 E. DOYLE ST., TOCCOA 30577
WEBSTER,BRUCE S. 60 ACT EM
RT. 3, BOX 399-A, TOCCOA 30577

61—SUMTER
(Marion, Schley, Sumter, Taylor, Webster)

ANDERSON,W. R. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709
ASTON,JAMES K. 61 ACT R
712 FORSYTH ST., AMERICUS 31709
COLLINS,ROBERT A. 61 ACT SU
212 REESE ST., AMERICUS 31709
DUDLEY,A. G. 61 DE4 OBG
205 S. LEE ST., AMERICUS 31709
DUDLEY,JAMES C. 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
DURHAM,BON M. 61 ACT I
142 S. JACKSON ST., AMERICUS 31709
GATEWOOD,T. SCHLEY 61 ACT OBG
205 SOUTH LEE STREET, AMERICUS 31709
HERRON,JAMES G. 61 ACT I
1102 E. LAMAR AVE., AMERICUS 31709
KEULS,HANS A. 61 ACT OBG
1102 E. LAMAR ST., AMERICUS 31709
MATHIS,MARTHA 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709
MONTGOMERY,R. C.,II 61 ACT
BUTLER 31006
ROBERTS,SAVA M. 61 ACT R
P.O. BOX 2938, AUGUSTA 30904
ROBINSON,JOHN H.,III 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
RUNDLE,T. J. 61 ACT OPH
P.O. BOX 1026, AMERICUS 31709
SAMARA,DAVID J. 61 ACT U
1102 E. LAMAR ST., AMERICUS 31709
SAMS,FRANK H.,JR. 61 ACT FP
BOX 536, REYNOLDS 31076
SANKARAN,K. N. V. 61 ACT PD
1102 E. LAMAR ST., AMERICUS 31709

SAVAGE,C. P. 61 DE5 FP
MONTEZUMA 31063
SIMPSON,HARVEY L. 61 ACT SU
1102 LAMAR ST., AMERICUS 31709
SNEAD,JOSEPH A. 61 ACT OR
1102 E. LAMAR ST., AMERICUS 31709
TAN,HO T. 61 ACT ANES
P.O. BOX 1105, AMERICUS 31709
TEAFORD,HENRY ST.GEORGE,JR. 61 ACT SU
629 E. FORSYTH ST., AMERICUS 31709
THOMAS,RUSSELL 61 DE1
131 SOUTH JACKSON STREET, AMERICUS 31709
THOMPSON,F. H. 61 ACT PATH
AMERICUS 31709
WADE,V. C. 61 ACT FP
1102 E. LAMAR ST., AMERICUS 31709
WALDEMAYER,E. W. 61 ACT FP
629 E. FORSYTH ST., AMERICUS 31709
WHATLEY,E. C. 61 ACT
REYNOLDS 31076
WILSON,FRANK A.,III 61 ACT I
LESLIE 31764

62—ST. JOHN'S PARISH
(Liberty)

BAUTISTA,GRACE C. 62 ACT PD
P.O. BOX 406 FRASER DR., HINESVILLE 31313
BAUTISTA,VICTOR C. 62 ACT ANES
LIBERTY MEMORIAL HOSP., HINESVILLE 31313
FRASER,WHITMAN 62 ACT FP
FRASER DRIVE, HINESVILLE 31313
ROBBINS,FRANK T. 62 ACT FP
513 OGLETHORPE BLVD., HINESVILLE 31313
SHIH,CHEN-WEN 62 ACT OBG
P.O. BOX 406, HINESVILLE 31313
SILAN,J. RUBEN D. 62 ACT SU
P.O. BOX 844, HINESVILLE 31313

64—TELFAIR

MANN,FRANK R.,JR. 64 ACT
MCRAE 31055
MCRAE,D. B. 64 ACT SU
MCRAE 31055
MUNSAYAC,LUMAWIG Y. 64 ACT FP
BOX 487,MAIN ST., LUMBER CITY 31549
SMITH,F. A.,JR. 64 ACT FP
MCRAE 31055

65—THOMAS AREA
(Brooks, Grady, Thomas)

ARNETT,THOMAS E. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
BELL,RUDOLPH 65 DE5 U
P.O. BOX 1675, THOMASVILLE 31792
BENTLEY,ALONZO J. 65 ACT OALR
918 S. BROAD ST., THOMASVILLE 31792
BOSWELL,W. C. 65 DE5 PD
P.O. BOX 1378, THOMASVILLE 31792
BRIDGES,WILLIAM Z. 65 ACT OPH
808 GORDON AVE., THOMASVILLE 31792
BRINSON,JOHN B.,JR. 65 ACT FP
808 GORDON AVE., THOMASVILLE 31792
CAIN,ROBERT T. 65 ACT FP
P.O. BOX 231, QUITMAN 31643
CARICO,JAMES M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
CHRISTENSEN,EUNICE H. 65 R ANES
J. D. ARCHBOLD HOSP., THOMASVILLE 31792
CHRISTENSEN,EVERETT D. 65 ACT FP
J. D. ARCHBOLD HOSP., THOMASVILLE 31792
COURSON,HERMAN C. 65 ACT I
P. O. BOX 1939, THOMASVILLE 31792
DUNAWAY,MARSHALL C. 65 ACT I
900 GORDON AVE., THOMASVILLE 31792
FALBAUM,HARTLEY L. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792
FERNANDEZ,JOSE A. 65 ACT FP
1904 SW 22ND AVENUE, MIAMI, FL 33145
FONTANA,NORVERTO A. 65 ACT FP
P. O. BOX 1867, THOMASVILLE 31792
GALL, HENRY, 65 DE5 FP
P.O. BOX 502, CAIRO 31728
HANCOCK,S. L. 65 DE1
2ND AVE. SE, CAIRO 31728
HODGES,C. HUBERT,JR. 65 ACT U
808 GORDON AVE., THOMASVILLE 31792
JACKSON,ROBERT W. 65 AF ORS
P. O. BOX 978, THOMASVILLE 31792
JARRETT, EUGENE C.,III 65 ACT PD
SOUTHWESTERN STATE HOSP, THOMASVILLE 31792
KAPROTH,DAVID E. 65 ACT FP
503 GORDON AVENUE, THOMASVILLE 31792
KING,J. T. 65 ACT OALR
THOMASVILLE 31792
KING,JOHN T.,JR. 65 ACT
P. O. BOX 1919, THOMASVILLE 31792
LANE,GEO M. 65 ACT R
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
LARDIN,WILLIAM A. 65 ACT ANES
ARCHBOLD MEMORIAL HOSP, THOMASVILLE 31792
LEAR,THOMAS F.,JR. 65 ACT SU
P. O. BOX 1912, THOMASVILLE 31792
LITTLE,FRANK A. 65 ACT ANES
109 TUXEDO DR., THOMASVILLE 31792
MALONE,RANDOLPH A. 65 ACT PD
413 GORDON AVENUE, THOMASVILLE 31792
MAXWELL,ROBERT B. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792
MCCOLLUM,WILLIAM 65 ACT
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
MCKENZIE,DONALD J. 65 ACT U
935 S. BROAD ST., THOMASVILLE 31792
MIDDLETON,MILTON G. 65 ACT
MENTAL HEALTH CENTER, THOMASVILLE 31792
MILLER,FRANK R. 65 ACT PD
509 GORDON AVE., THOMASVILLE 31792
MIMS,OSCAR M. 65 ACT I
THOMASVILLE 31792
MORTON,WM. J. 65 ACT FP
S. BROAD ST., CAIRO 31728
MULLER,GERALD B. 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
MURPHY,FRED E.,JR. 65 ACT OR
THOMASVILLE 31792
NEEL,JULIAN B. 65 ACT SU
207 E. JACKSON ST., THOMASVILLE 31792
PAYNE,JOHN F. 65 ACT OR
210 W. HANSELL ST., THOMASVILLE 31792
PEPIN,HENRY S. 65 ACT FP
602 E. SEIXAS ST., THOMASVILLE 31792
PETTIT,MANSON B. 65 ACT P
TUXEDO DR., THOMASVILLE 31792
RAWLINGS,JOE D. 65 ACT FP
918 S. BROAD ST., THOMASVILLE 31792
REID,JAMES W. 65 DE5
THOMASVILLE 31792
REYNOLDS,G. THOMAS 65 ACT OBG
918 S. BROAD ST., THOMASVILLE 31792
ROMINE,BENJAMIN W. 65 ACT FP
P.O. BOX 232, QUITMAN 31643
SHEALY,L. M. 65 ACT FP
P. O. BOX 631, QUITMAN 31643
SHEPARD,KIRK 65 DE1 SU
204 JURMIS ST., THOMASVILLE 31792
SINGLETON,C. K. 65 ACT
FIRST AVENUE SE, CAIRO 31728
STORY,JAMES L. 65 ACT SU
505 GORDON AVE., THOMASVILLE 31792

STRESE,FRITZ W. 65 ACT FP
ARCHBOLD MEM. HOSP., THOMASVILLE 31792
TANNER,MAURICE B. 65 ACT R
PO BOX 1001, THOMASVILLE 31792
TAYLOR,JAMES P. 65 ACT OBG
507 GORDON AVE., THOMASVILLE 31792
TAYLOR,WARREN A. 65 ACT SU
PROF. BLDG. SIEXAS ST., THOMASVILLE 31792
TREVEJO,WILLIAM A. 65 ACT ANES
1616 E. WASHINGTON ST., THOMASVILLE 31792
TUCK,ALBERT C.,DDS 65 AF
P.O. BOX 978, THOMASVILLE 31792
WATT,CHARLES H.,JR. 65 ACT SU
900 GORDON AVE., THOMASVILLE 31792
WATT,WILLIAM VANCE 65 ACT SU
900 GORDON AVENUE, THOMASVILLE 31792
WINE,MERVIN B. 65 ACT AL
THOMASVILLE 31792
ZAVALETA,A. A. 65 ACT TS
GORDON AVE., THOMASVILLE 31792

66—TIFT

BOWYER,FRANK P. 66 ACT PD
418 N. PARK AVE., TIFTON 31794
BRIDGES,W. L.,JR. 66 ACT PD
714 E. 18TH, TIFTON 31794
DAVIS,F. MORRIS 66 ACT FP
820 TIFT AVE., TIFTON 31794
DAVIS,TERRELL L. 66 ACT PD
418 N. PARK, TIFTON 31794
DIXON,SAMMIE 66 ACT OBG
1493 KENNEDY RD., TIFTON 31794
EDMONDSON,T. L. 66 ACT FP
TIFTON 31794
FLOWERS,EUGENE MONROE 66 ACT FP
TIFTON 31794
GILBERT,STEWART D. 66 ACT R
TIFT GENERAL HOSP., R TIFTON 31794
HOLLOWAY,WILMER O. 66 ACT
P.O. BOX 388,210 VICTOR DR., TIFTON 31794
HUGHES,RONALD M. 66 ACT OPH
P.O. BOX 986, TIFTON 31794
JARRETT,HENRY K.,JR. 66 ACT U
113 EAST SECOND STREET, TIFTON 31794
KARSTEN,MIKELL B. 66 ACT SU
P.O. BOX 989, TIFTON 31794
KING,WILLIAM D. 66 ACT OBG
1493-A KENNEDY RD., TIFTON 31794
KIRKPATRICK,J. F.,JR. 66 ACT SU
714 E. 18TH ST., TIFTON 31794
LUCAS,PAUL WARREN 66 ACT OALR
TIFTON 31794
PITTMAN,CARL S. 66 DE5
TIFTON 31794
PITTMAN,CARL S.,JR. 66 ACT FP
TIFTON 31794
PRIETO,EDWARD A. 66 ACT ANES
P.O. BOX 132, TIFTON 31794
SAPP,GERALD L. 66 ACT OR
P.O. BOX 1368, TIFTON 31794
SMITH,DON T. 66 ACT FP
1824 N. LEE ST., TIFTON 31794
SMITH,ROBLEY D. 66 ACT FP
P. O. BOX 788, TIFTON 31794
TURNER,JOSEPH M. 66 ACT I
P. O. BOX 983, TIFTON 31794
WIGHT,ROBERT P. 66 ACT I
P. O. BOX 1186, TIFTON 31794
ZIMMERMAN,CHAS. 66 DE5 FP
TIFTON 31794
ZIMMERMAN,W. F. 66 DE1 FP
TIFTON 31794

68—TROUP
(Heard, Troup)

ALLEN,BARNA T.,JR 68 ACT I
303 SMITH ST., LAGRANGE 30240
ALMAND,JOSEPH M.,JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240
AUSTON,PAUL W. 68 ACT R
W. GA. MEDICAL CENTER, LAGRANGE 30240
BAILEY,A. GLENN 68 ACT SU
303 SMITH ST., LA GRANGE 30240
BASKIN,HENRY J. 68 ACT I
303 SMITH ST., LAGRANGE 30240
BROOKS, JAMES C. 68 ACT I
P.O. BOX 490127, ATLANTA 30349
BYARS,STEVENS 68 ACT PH
406 COUNTRY CLUB RD., LAGRANGE 30240
CHAMBERS,J. W. 68 ACT I
307 N. LEWIS ST., LAGRANGE 30240
CHOI,SUN IK 68 ACT ANES
801 CHEROKEE RD., LAGRANGE 30240
COPELAND,ROBERT B. 68 ACT I
303 SMITH ST., LAGRANGE 30240
CORDER,V. WOODARD 68 ACT ANES
P.O. BOX 191, WEST POINT 31833
COUSINS,ALBERT L. 68 S I
303 SMITH ST., LAGRANGE 30240
COWART,CHARLES T. 68 ACT SU
718 LA ROSE TERR., LAGRANGE 30240
DOLAN,JOSEPH A. 68 ACT OBG
311 S. LEWIS ST., LAGRANGE 30240
DUTTERA,MAURICE J.,JR. 68 ACT I
303 SMITH ST., LAGRANGE 30240
EASLEY,CURRAN S.,JR. 68 ACT PD
606 S. GREENWOOD ST., LAGRANGE 30240
FACKLER,WILLIAM B.,JR. 68 ACT I
LAGRANGE 30240
FISHER,GEORGE B. 68 ACT
FRANKLIN 30217
GRACE,KENNETH D. 68 ACT SU
206 CHURCH ST., LAGRANGE 30240
HAMMETT,H. HILT,JR. 68 ACT OALR
HAMMETT BLDG., LAGRANGE 30240
HENDI,SAMIR A. 68 ACT SU
HOSPITAL STREET, FRANKLIN 30217
HENDRICKS,WILLIS M. 68 ACT OBG
LAGRANGE 30240
HOLDER,J. S. 68 ACT SU
LAGRANGE 30240
HUTCHINSON,W. L. 68 ACT OBG
311 S. LEWIS STREET, LAGRANGE 30240
KILLEBREW,JAMES G.,JR 68 ACT OR
303 SMITH ST., LAGRANGE 30240
KRAFKA,JOSEPH F. 68 ACT PATH
CITY CO HOSP., VERNON RD, LAGRANGE 30240
LEVERETT,EDWARD 68 ACT
432 GORDON CIRCLE, LA GRANGE 30240
LEWIS,EARLE 68 DE1 I
303 SMITH ST., LAGRANGE 30240
LINZ,WERNER A. 68 ACT U
303 SMITH ST., LAGRANGE 30240
MADRELL,ROBERT S. 68 ACT OBG
311 S. LEWIS ST., LA GRANGE 30240
MAJOR,CECIL P. 68 ACT
303 SMITH STREET, LAGRANGE 30240
MCCRARY,GEORGE ALFRED 68 ACT OR
303 SMITH ST., LA GRANGE 30240
MITCHELL,J. T. 68 ACT R
CITY-COUNTY HOSPITAL, LAGRANGE 30240
MOLYNEAUX,E. W. 68 ACT FP
HAMMETT BLDG., LAGRANGE 30240
MORGAN,J. C. 68 DE5 SU
WEST POINT 31833
MORGAN,JAMES C.,III 68 ACT OPH
303 SMITH ST., LAGRANGE 30240
MORGAN,JAMES C.,JR. 68 ACT OALR
P. O. BOX 590, WEST POINT 31833
NAIK,MADHAV V. 68 ACT SU
ENOCH CALLAWAY CANCER CN, LAGRANGE 30240
NORMAN,LEWIS G.,JR. 68 ACT SU
WEST POINT 31833
ONEAL,R. S. 68 DE5 FP
LAGRANGE 30240
SHAH,NARENDRA K. 68 ACT R
CALLAWAY CANCER CLINIC, LAGRANGE 30240

SMITH,ROBERT R. 68 ACT SU
828 PINEY WOODS DR., LAGRANGE 30240
TIDWELL,OWEN K. 68 ACT R
CITY-COUNTY HOSP., LA GRANGE 30240
TURNER,J. R. 68 ACT
LAGRANGE 30240
WAMMOCK,HOKE 68 ACT SU
ENOCH CALLAWAY CANCER CLN, LAGRANGE 30240
WAMMOCK,VIRGENE S. 68 ACT D
771 LAKEWOOD DR., LA GRANGE 30240
WHITEHEAD,C. MARK 68 ACT U
CLARK HOLDER CLINIC, LAGRANGE 30240
WHITEHEAD,C. MARK,JR. 68 ACT U
303 SMITH ST., LAGRANGE 30240

69—UPSON
(Pike, Upson)

ALLEN,LAWRENCE LANIER 69 ACT FP
211 THURSTON STREET, THOMASTON 30286
ANTHONY,H.F.,JR. 69 ACT R
P. O. BOX 170, THOMASTON 30286
BALCOS, ORLANDO G. 69 ACT
BOX 128,DRS. CLINIC, ROBERTA 31078
BLACKBURN,J. D. 69 DE5 OR
711 HILL ST.,PO BOX 552, THOMASTON 30286
BREWTON,SAMUEL A. JR. 69 ACT U
612 W. GORDON RD., THOMASTON 30286
CARTER,ROBERT L. 69 DE5 FP
THOMASTON 30286
DALLAS,R. E. 69 ACT FP
211 E. THOMASTON ST., THOMASTON 30286
DALLAS,WM. M.,JR. 69 ACT SU
405 W. MAIN ST., THOMASTON 30286
DEEN,JOHNNY T. 69 ACT OPH
THOMASTON 30286
GARDNER,NORMAN P. 69 ACT FP
101 AVENUE F, THOMASTON 30286
GOWER,W. J. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286
HEAD,D. L.,JR. 69 ACT FP
E. THOMPSON ST., THOMASTON 30286
HOLLOWAY,ALFRED M. 69 ACT FP
405 W. MAIN ST., THOMASTON 30286
KELLUM,J. M. 69 ACT SU
THOMASTON 30286
OXFORD,WILLIAM M. 69 ACT SU
405 W. MAIN ST., THOMASTON 30297
PATRICK,JOHN W. 69 ACT R
301 CHARLES AVE., THOMASTON 30286
POTITONG,BANLU 69 ACT I
405 W. MAIN ST, BOX 752, THOMASTON 30286
POTITONG,PRATOOM 69 ACT PD
405 W. MAIN ST, BOX 752, THOMASTON 30286
SAPPINGTON,T. A. 69 ACT FP
612 W. GORDON ST., THOMASTON 30286
SHACKLETT,ROBERT S. 69 ACT PATH
UPSON CO HOSP, BOX 1059, THOMASTON 30286
TYLER,HERBERT D. 69 ACT I
P.O. BOX 710, THOMASTON 30286
WOODALL,JAMES A. 69 ACT
316 W. GORDON ST., THOMASTON 30286
WOODALL,WM. PRUITT 69 ACT
316 W. GORDON ST., THOMASTON 30286
ZUNIGA,WILLY E. 69 ACT
260 SCANDIA CIRCLE, ATHENS 30601

70—WALKER-CATOOSA-DADE

ADAMS,JOHN W.,JR. 70 ACT PATH
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30741
ADKINS,THOMAS E. 70 ACT FP
789 CHICKAMAUGA AVE., ROSSVILLE 30741
ALISAGO,ANDRES J. JR. 70 ACT ANES
HUTCHESON MEM. HOSP, FT OGLETHORPE 30741
CASH,TED D. 70 ACT FP
162 EUCLID AVE., CHICKAMAUGA 30707
CASTILLO,ANTONIO R. 70 ACT FP
214 ANDREWS ST., ROSSVILLE 30741
COCHRAN,T. A. 70 ACT FP
RINGGOLD 30736
CRAWLEY,WILLIAM D. 70 ACT OBG
787 CHICKAMAUGA AVE., ROSSVILLE 30741
CURETON,M. K. 70 DE5 PH
6 SUNSET DR., LAFAYETTE 30727
CURETON,RICHARD K. 70 ACT R
HUTCHESON HOSP., FT. OGLETHORPE 30742
CURTIS,THOMAS H. 70 ACT OBG
1816 LAFAYETTE RD., FT. OGLETHORPE 30742
DERRICK,HOWARD C.,JR. 70 ACT FP
LAFAYETTE 30728
DUHON,FRED J. 70 ACT FP
DOCTORS CLINIC, LAFAYETTE 30728
ELROD,BRUCE A. 70 ACT PATH
P.O. BOX 2042, FT. OGLETHORPE 30742
GOOLSBY,SARA L. 70 ACT
211 ANDREWS ST., ROSSVILLE 30741
GREENE, RALPH R. 70 ACT FP
P.O. BOX 460, RINGGOLD 30736
HANSEN,RICHARD A. 70 ACT FP
WILDWOOD HOSP., WILDWOOD 30757
HAYES,THOMAS E. 70 ACT SU
102 MEMORIAL MEDICAL BLDG CHATTANOOGA 37404
HILLIS,CHARLES L. 70 ACT FP
P. O. BOX 846, LAFAYETTE 30728
HIXSON,GORDON L. 70 ACT R
TRI COUNTY HOSPITAL, FT. OGLETHORPE 30742
HUTCHISON,NORTON H. 70 R FP
P.O. BOX 366, BELL BUCKLE,TN 37020
JOHNSON,E. G. 70 ACT SU
102 MEMORIAL MEDICAL BLDG CHATTANOOGA 37404
JONES,ROBERT T. 70 S
LAFAYETTE 30728
KINARD,GARLAND E. 70 ACT FP
118 HOWARD ST., ROSSVILLE 30741
KITCHENS,S. B. 70 DE5 FP
LAFAYETTE 30728
KOCACITAK,SAHIN S. 70 ACT SU
TRI-COUNTY HOSP., FT. OGLETHORPE 30742
LASKY,RICHARD S. 70 ACT U
1010 E. THIRD ST., CHATTANOOGA, TENN 37403
MARTYNSKI,STANISLAW 70 ACT PD
HUTCHESON MEM. HOSP., FT. OGLETHORPE 30742
PARK,IH KOO 70 ACT SU
102 MEMORIAL MED BL, CHATTANOOGA TN 37404
POPE,ROY JR. 70 ACT FP
CHICKAMAUGA 30707
SANCHEZ,FRANCISCO R. 70 ACT FP
1800 LAFAYETTE RD., FT. OGLETHORPE 30742
SIMS,J.P. 70 ACT FP
1 THOMAS RD., FT. OGLETHORPE 30742
SMILEY,F. JONES 70 ACT OBG
1816 LAFAYETTE RD., FT. OGLETHORPE 30742
SWIFT,CHARLES RAY 70 ACT PATH
3827 RINGGOLD RD., CHATTANOOGA, TN. 37412
TERRELL,WARREN 70 ACT ANES
1719 JOHN ROSS RD., CHATTANOOGA.,TN 37412
VASSEY,G. C. 70 ACT FP
791 CHICAMAUGA AVE., ROSSVILLE 30741

71—WALTON

BARTON,JAMES HOWARD 71 ACT
SOCIAL CIRCLE 30279
BRISCO,C. D. 71 DE5 I
MONROE 30655
ENSLEN,PHILLIP J. 71 ACT FP
247 ALCOVA ST., MONROE 30655
FOSTER,CATHERINE E. 71 ACT OBG
924 W. SPRING ST., MONROE 30655
HUIE,LYNN M. 71 ACT FP
MONROE 30655

MORELAND,C. C. 71 ACT
WALTON CLINIC, MONROE 30655
TANKESLEY,ROBERT M. 71 ACT R
437 PLANTATION DR., MONROE 30655

72—WARE
(Bacon, Brantley, Pierce, Ware)

ADKINS,H. T. 72 A PH
P. O. DRAWER 1110, WAYCROSS 31501
BAGLEY,CHARLES E. 72 ACT FP
P.O. BOX 220, ALMA 31510
BATES,ROGER A. 72 ACT SU
410 ZACHRY ST., WAYCROSS 31501
BATES,W. B.,JR. 72 ACT FP
WAYCROSS 31501
BICKERSTAFF,JAMES W.,JR 72 ACT OR
1921 ALICE ST., WAYCROSS 31501
BROWN,EDWARD B. 72 ACT OBG
P. O. BOX 177, WAYCROSS 31501
CALHOUN,W. C. 72 ACT OB
P. O. BOX 1091, WAYCROSS 31501
CARBAUGH,ROBERT G. 72 ACT ANES
1921 ALICE ST., WAYCROSS 31501
CLARK,SPURGEON WM.,JR. 72 ACT OPH
P. O. BOX 951, WAYCROSS 31501
DAVIS,ALFRED L.,JR. 72 ACT PD
P. O. BOX 71, BLACKSHEAR 31516
DAVIS,FLOYD E. 72 ACT FP
1921 ALICE ST., WAYCROSS 31501
DUANE,LAWRENCE .,JR 72 ACT R
P.O. BOX 938, WAYCROSS 31501
DURRENCE,LEONARD C.,JR. 72 ACT FP
BLACKSHEAR CLINIC, BLACKSHEAR 31516
FARRIS,JOHN DUNCAN 72 ACT OBG
P. O. BOX 177, WAYCROSS 31501
FERRELL,T. J.,JR. 72 ACT I
1921 ALICE ST., WAYCROSS 31501
FLESCH,W. L. 72 ACT U
P.O. BOX 2007, WAYCROSS 31501
GOLDWASSER,FRED E. 72 ACT FP
ALMA 31510
HEATH,GEORGE S. 72 ACT FP
P. O. BOX 1131, WAYCROSS 31501
HEATH,HEZEKIAH K.,JR. 72 ACT
P. O. BOX 1131, WAYCROSS 31501
HENDRY,KATHERINE MCM. 72 ACT FP
P.O. BOX 408, BLACKSHEAR 31516
HENDRY,WM. A. 72 DE1 FP
BLACKSHEAR 31516
HOWARD,PEGGY J. 72 ACT OBG
408 ZACHRY ST., WAYCROSS 31501
JACOBS,IVEY 72 ACT ALR
P. O. BOX 882, WAYCROSS 31501
JACOBS,L. DAVIS 72 ACT FP
403 LISTER ST., WAYCROSS 31501
JOSEF,AVELINO S. 72 ACT SU
203 S. DIXON ST., ALMA 31510
LEE,WALTER E.,JR. 72 ACT FP
BOX 737, WAYCROSS 31501
LEWIS,WILEY B. 72 ACT FP
1507 ALICE ST., WAYCROSS 31501
LOPEZ,ERNESTO G. 72 ACT PATH
WAYCROSS MEM. HOSP., WAYCROSS 31501
MARTINEZ,JOS. 72 ACT ANES
MEM. HOSP., WAYCROSS 31501
MCCLARIN,WILLIAM M.,JR. 72 ACT D
202 FOLKS ST., WAYCROSS 31501
MCGOOGAN, M.T. 72 ACT SU
1921 ALICE ST., WAYCROSS 31501
OCONNELL,MICHAEL J. 72 ACT OR
1507 ALICE ST., WAYCROSS 31501
PACKER,ROBERT M.,JR. 72 ACT I
P.O. BOX 899, WAYCROSS 31501
POMEROY,W. L. 72 DE5 SU
WAYCROSS 31501
POMEROY,WILLIAM L.,JR. 72 ACT I
410 ZACHRY STREET, WAYCROSS 31501
SHUMAN,VILDA 72 ACT PD
WAYCROSS 31501
SMITH,LEO 72 ACT OALR
BOX 778, WAYCROSS 31501
SMITH,ROBERT C. 72 ACT R
P. O. BOX 938, WAYCROSS 31501
STEBLER,MICHAEL E. 72 ACT PATH
MEMORIAL HOSPITAL, WAYCROSS 31501
TAYLOR,JAMES W. 72 ACT OPH
P.O. BOX 778, WAYCROSS 31501
TERRY,D.B. 72 ACT FP
HOMERVILLE 31634
TERRY,DANIEL B.,JR 72 ACT SU
403 LISTER ST, WAYCROSS 31501
THOMPSON,CLEVELAND,III 72 ACT SU
410 ZACHRY ST., WAYCROSS 31501
TRIANA,CARLOS R. 72 ACT SU
PATTERSON 31557
VICTOR,SAMUEL 72 ACT FP
300 PINEVIEW DR., WAYCROSS 31501
WATERS,DONALD B. 72 ACT FP
BLACKSHEAR 31516
WAXLER,EDWARD B. 72 ACT I
P.O. BOX 899, WAYCROSS 31501
WILSON,OHLEN RUDOLPH 72 ACT
ALMA 31510
WYNN,O. C. 72 DE5 FP
861 FOLKS ST., WAYCROSS 31501
YEOMANS,NEAL F. 72 ACT R
WAYCROSS 31501

74—WASHINGTON

GILMORE,THOMAS W.,JR. 74 ACT I
P. O. BOX 190, SANDERSVILLE 31082
HELTON,B. L. 74 DE5 FP
524 WASHINGTON AVE., SANDERSVILLE 31082
HELTON,WILLIAM S. 74 ACT FP
522 WASHINGTON AVE., SANDERSVILLE 31082
HOLMES,DEAN LEE 74 ACT
524 SPARTA RD., SANDERSVILLE 31082
HURT,MARION W. 74 ACT FP
109 W. CHURCH ST., SANDERSVILLE 31082
RAWLINGS,WILLIAM 74 ACT FP
524 SPARTA RD., SANDERSVILLE 31082
TAYLOR,WILLIAM E. 74 I&R FP
SMITH ST., TENNILLE 31089

75—WAYNE

BRANTLEY,JAMES W. 75 ACT SU
P.O. BOX 1133, JESUP 31545
HARRELL,E. L. 75 ACT
RT. 4,BOX 424, JESUP 31545
HITT,WILLIAM A. 75 ACT FP
STE.216,520 OCEAN BLVD., ST. SIMON'S 31522
HOLLOWAY, JOHN T. 75 ACT FP
1101 CHURCH ST., WAYCROSS 31501
MCGAHEE,OLLIE O.,JR. 75 ACT FP
P. O. BOX 937, JESUP 31545
MILLER,ROBERT E. 75 ACT
166 MEMORIAL DR., JESUP 31545
MOODY,RICHARD A. 75 ACT
P. O. BOX 456, JESUP 31545
PUMPELLY,ROBERT A. 75 ACT FP
166 MEMORIAL DR., JESUP 31545
YEOMANS,JAMES W. 75 ACT SU
P. O. BOX 67, JESUP 31545

76—WHITEFIELD-MURRAY

BARNWELL,WILLIAM L. 76 ACT OPH
1217 MEMORIAL DRIVE, DALTON 30720

BLACKMAN,WILLIAM M. 76 ACT OPH
1217 MEMORIAL DR., DALTON 30720
BOGGESS,NEIL D.,JR. 76 ACT FP
1012 BURLEYSON DR., DALTON 30720
BOOZER,ALBERT MARION 76 ACT FP
DALTON MEM. ARTS BLDG., DALTON 30720
BOWERS,ROBERT E. 76 DE2 FP
721 GLENWOOD DR., CHATTANOOGA, TENN. 37404
BRADLEY,PAUL L. 76 ACT SU
P.O. 1969, DALTON 30720
BRADLEY,R. H. 76 DE5
CHATSWORTH 30705
CARSON,W. P. 76 ACT SU
P. O. BOX 129, DALTON 30720
CHEATHAM,JAMES S. 76 ACT P
201 S. HAMILTON ST., #408, DALTON 30720
CHEVRES, FRANCISCO, 76 S FP
1401 BURLEYSON DR., DALTON 30720
COUNCIL,BENJAMIN P. 76 ACT OTO
1305 BROADRICK DR., DALTON 30720
DARDIN, M. VICTOR, 76 ACT OBG
P.O. BOX 989, DALTON 30720
EASLEY,CONRAD H. 76 ACT OR
1203 MEMORIAL DR., DALTON 30720
EIDSON,RODGER H. 76 ACT OBG
MEDICAL ARTS BLDG., DALTON 30720
FARROW,ROYAL T. 76 ACT PD
MEDICAL ARTS BLDG., STE E, DALTON 30720
FELKER,FORT F.,JR. 76 ACT
216 N. PENTZ ST., DALTON 30720
FORSHNER,JOHN G. 76 ACT D
1217 MEMORIAL DR., DALTON 30720
GENT,JACK 76 ACT SU
P.O. BOX 1969, DALTON 30720
GIDDENS,RICHARD D. 76 ACT SU
MEDICAL ARTS BLDG., DALTON 30720
GILBERT,CARL N. 76 ACT PD
MEDICAL ARTS BLDG., DALTON 30720
GREGORY,JAMES R. 76 ACT OBG
MEDICAL ARTS BLDG., DALTON 30720
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MCGHEE,EARL T. 76 ACT FP
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1109 BURLEYSON DRIVE, DALTON 30720
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RIGBY,JUDY A. 76 ACT PD
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RIZO,MIGUEL A. 76 ACT P
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SUMMEROUR,BROOKE F. 76 ACT ANES
P. O. BOX 252, DALTON 30720
SUTTER,LUTHER O. 76 ACT FP
120 WALNUT, CHATSWORTH 30705
TEH,JACK B. 76 ACT PATH
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W. WALNUT AVE., CHATSWORTH 30705
WELLS,DAVID A. 76 ACT FP
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WHITFIELD,T. W. 76 ACT FP
1221 MEMORIAL DR., DALTON 30720
WINTRUP,CHARLES K. 76 ACT EM
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WASHINGTON 30673
POLLOCK,JOHN EDWARD JR. 78 ACT FP
GORDON ST., WASHINGTON 30673
WILLS,C. E.,JR. 78 ACT FP
WASHINGTON 30673

79—WORTH

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EASON,HARMER O.,JR. 79 ACT I
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MORGAN,ROBERT T. 79 ACT FP
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STONER,W. P. 79 ACT FP
SYLVESTER 31791
TRACY,J. L.,JR. 79 ACT FP
SYLVESTER 31791



METROPOLITAN PSYCHIATRIC

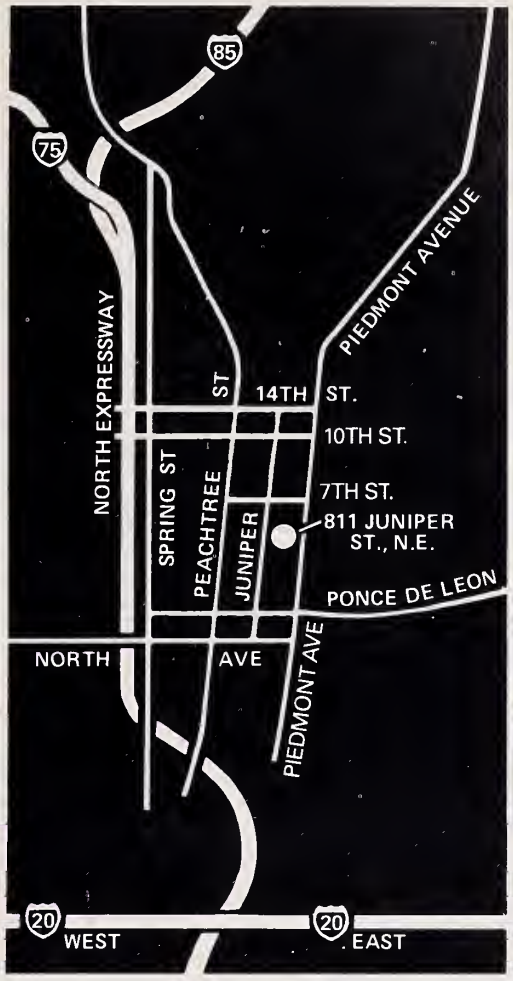
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In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment, but always within the theme of individualized care.

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- Individual Psychotherapy
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cal, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

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